James Crosson 10-03735 UNK UNK

388

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State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 15, 2010 1000 hrs Medical Examiner James Robert Crossan, 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 50 Cedar Hill Circle North East Cecil 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 10/11/2003 163-82-0635 1X M 2 F 6 **Penn**sylvania Yrs Usual Residence of Decedent any 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XXYes 2 No 28a-f show Maryland | Cecil North East permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28a-f she injury or other traumatic event, the Medital Examiner must be anofficed at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Cedar Hill Circle United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No 1 Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White þ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Education Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) James Robert Crossan, Jewel Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Ring / Grandmother 1006 Hopewell Road, Oxford, Pennsylvania 19363 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State May 25, 8 Other Specify Oxford Cemetery 4 Donation 2010 Oxford, Pennsylvania 22. Name and Address of Facility Crouch Funeral Home 21. Signature of 127 South Main street, North East, Maryland 21901 heast or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Smoke inhalation Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to mmediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Physician/Medical X UNPENDED AMENDED 23a, 27, 28a-f, per ME g909 11/18/10 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the at the detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been subneral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical æ Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other Scene ER/Outpatient 3 DOA 1 Yes 2 No 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: subject was victim of house fire Fd 10:00 am 1 Yes 2 No Natural Director: 5 Pending 5/15/10 Accident 2 Investigation 28f. Location (Street and Number or Rural Route Number, City, or Town, State) 50 Cedar Hill Circl North East, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be within 24 hours a. To the Funeral L determined Homicide <u>Residence</u> 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated hature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 16, 2010 refe and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Laron Locke MD. 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

SHAINA CROSSON Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2010 16502 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day May 15, 2010 1000 hrs Medical Examiner Shaina Melissa Crossan 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death North East 50 Cedar Hill Circle Cecil 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 2XF Country) Pennsylvania 1 ___ M 197-80-7977 10/03/2002 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked oulter than "natural", or items 23a or 28a-f she fijury or other traumatic event, the Medical Examiner must be notified at once North East Maryland Cecil Director 10f. Zip Code 10g. Citizen of What Country? 50 Cedar Hill Circle 21901 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Specify: White ፩ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than " Baltimore, MD 21215-0036 Student Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Robert Crossan, Sr. Jewel Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Ring / Grandmother 1006 Hopewell Road, Oxford, Pennsylvania 19363 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State May 25, Cremation 3 Removal from State crematory or other place) 1 X Burial 2 Oxford Cemetery 2010 Oxford, Pennsylvania 4 Donation 5 Ott 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and Micdiesi Death Smoke inhalation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and -Physician/Medical X UNPENDED AMENDED 23a,27,28a-f, per ME g909 11/18/10 TT attending physician or use as the bunal Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. à 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 Yes 28b. Time of Injury After 28d Describe how injury occurred subject was victim of house fire 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? Certification: Natural 5 Pending 24 hours after death. Director: d in by the f Fd 10:00 am 5/15/2010 2 X Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 50 Cedar Hill Circl North East, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be determined residence (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 16, 2010 Kelly 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

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Amend #17 per Inf G904 6/30/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day MAY 1:15 A_M 2010^{ear} VICTORIA ANDRADE DE DIAZ 8 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Hours Min. (Month, Day, Ye El Salvador **Director** 68 none Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked of other than "natural", or items 23a or 28a-f show up or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Bethesda 1xx Yes 2 □ No Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20817 El Salvador 10002 Mayfield Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1₺ Yes 2□No Specify: Salvadorian Hispanic If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Housewife none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Guadalope Andrade Dorotco Diaz Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jose Diaz (Son) 10002 Mayfield Drive Bethesda, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or oth Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5/20/2010 Ciudad Dolores 4 ☐ Donation 5 ☐ Other (Specify) Cementerio General 22. Name and Address of Facility Marshall's Funeral Home, 21. Signature of Funeral Service Licenses 20011 marshall 4217 9th Street, N.W. Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 23 Mo Immediate Cause (Final Ph sician/ ledical resulting in death) _xaminer Sequentially list not cities if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ History of ST elevation mycoodial interction Completed 1 Yes 2 No 3 Probably 4 Unknown History of non Stelevation myrocordial infarction 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Augustin State death.

To the Funeral Director: After this certificate has ampleted filled in by the funeral director, page? autopsy 1 Yes 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 2 No 1 🗌 Yes 1 ★ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certife

WWW W. W IL - 036.120206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMED FAROOQUI 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 3 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decement's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Arnold 535 Bay Hills Drive 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 19<u>20</u> 1 □ M 2 🗓 I Months Days May 24, 89 New York 130-07-6668 Director Yrs. Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location Arnold 10d. Inside City Limits Director MD Anne Arundel Examiner must be notified 1 Yes 2 No 5 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 21012 USA 535 Bay Hills Drive items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or \$ 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be fill of Health and Mental it: If item 27 is marked Rose Denert William Perry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 535 Bay Hills Drive Arnold, MD 21012 19a. Informant's Name/Relationship (Type, Print) Joseph J. Domotor / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If itel any injury or oth 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arthorono Nathonal June 16, Arlington, VA Cemetery 21. Signature of Funeral Service Licensee Barrantodies Soils, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIONYO Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of sician and burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 menths?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 9 Unknown P.O. ò signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Hospital or Attending Physician; The law requires 3 Probably 4 ☐ Unknown Completed 1 Yes 2 No page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 46 To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 | Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and title of certifie 29b. Signature 29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MAUII) qv, 8 Dolan 5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 414 Salisbury Road Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/22/1960 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ₹ M 2 □ F 50 215-90-6466 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 Is merked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits nd Mental Hygiene. merked other than "natural", or items 23a or 28a-f show imatic event, the Medical Evantinar must be notified at 10a. State 1 □Yes 2 No Funeral Director Anne Arundel Edgewater Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21037 USA 414 Salisbury Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 Mi No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Tree Trimmer Tree Service 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Importent: If Item 27 is merked eny injury or other traumatic evonce. Lindburgh Dolan Betty Aisquith ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles L. Dolan/ Brother 25909 Dogwood Rd., Greensboro, MD 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Cemetery 5/13/10 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD 21. Signature of Forestal Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Kidnox **Physician** Conte disease or condition resulting in death) /Medical Due to (or as a snsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) physician and stransit the burial-transit To the Hospital or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 ☐ Other (specify) signed by the e 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1□Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760, Records, Division of Vital hours after death. filled in by the f within 24 hours a

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

0 31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Suite 300

29d. Date signed (Month, Day, Year)

Dangolus 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2010 Physician/ 6:50 AM May 18, Mary Magdaline Dyson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown 23235 Spalding Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Month, Day re. **Funeral** Months Days Hours Min. 1 M 2 X F 98 1911 June Maryland Director 217-80-4314 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🏝 No Leonardtown St. Mary's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 20650 23235 Spalding Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. larked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Drury Chunn Williams Ada Mae John permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Martha Greene / Daughter 24600 W. Montego Rd. Hollywood, MD Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State May 21, 2010 | Great Mills, MD Holy Face Cemetery 4 Donation 5 Other (Specify) ure of Funeral Service Name and Address of Facility Mattingley-Gardiner Funeral Home. 2.0.Box 270 Leonardtown, MD 20650 P.O. Box 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immissifate cause. Enter Underlying Cause (Disease or linjury Examine The law requires that the death certificate be executed the attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Day Month detached g Unknown g Unknown signed by t. Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director After this certificate has been sixto the Funeral Director. After this completed filed in by the funeral director, page 2 should I 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 P No prior to completion of cause of death? 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 B Residence 6 Other (Specify) 2 🛺 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔊 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🕮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title o 29c. License number Pr person who completed cause of death (Item 23a) (Type, Print) 17697

Registrar

State

24035 Three Notch Road, Hollywood, MD 20636

MD

Jarboe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 9, 2010 Year **Physician** Clare 10:19 p Davenport /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) 6, 1921 Chevy Chase er 1 Year | If Under 24 Hrs. 3405 Kenilworth Drive Montgomery If Under 1 Year Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 ☐ F 091-14-6796 88 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County , or itema 23a or 28a-f show engine must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3405 Kenilworth Drive 20815 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status the Medical Examiner filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 2 3 XWidowed 4 ☐ Divorced White Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental James Bernard Sullivan Olga Baron 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pat Davenport/Daughter 10012 Fleming Avenue, Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of Pant: If Ite ö 1 Surial 2 ☐ Cremation 3 ☐ Removal from State May 14, permit. Page Department of Important: If any injury or once. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Addesin Funeral Home Inc. 500 University Elvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the shock, or heart fillure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** €1'OSC e years resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 pronths?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown been signed by should be detac Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 2 No 1 ☐ Yes 1 🗌 Yes : After this certificat funeral director, p To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident in by the within 24 hours after deal 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Rockville Pike, BIOO, Rockville, MD 20002 30 Name and address of person who completed cause of death (1 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2010 Month **Physician** 6:10 A May 6, Dergileva Leonidovna Irina /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 1924 Dundee Road Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Jan. 22, 1959 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funeral Days Months Hours 1 □ M 2 🗹 F 51 Ukraine 215-49-0535 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Examinat must be rediffed at once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Y Yes 2 □ No Director Rockville MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1924 Dundee Road 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2【No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 K If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Programmer Booz Allen Hamilton 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Vera Grigorievna Kominar Leonid Nikolaevich Amelkovych ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alexander Ignatov/Husband 1924 Dundee Rd., Rockville, Md. 20850 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 10 2010 10, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Foreral Service MO1315 DC 20007 2222 Wisconsin Ave., N.W. Washington, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Liver Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Breast Cancer Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be executed a 24 hours attendeath.

1-24 hours attendeath.

1-25 Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760 To the Vithin 2

IICal Evallill	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
iyəlcidi izinde	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23d. Date of delivery Month Day Year							
	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown						
nal dilloc	•;	24a. Was an autopsy parforme 1 □Yes 2 2							
2	25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5X Residence 6 □Other (Specify)						
	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred						
7	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)						

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

MD17402

29d. Date signed (Month, Day, Year)

May 7, 2010

State Registrar

Medical

29a Certifier

29b. Signature and title of certifier

Sandra Meta Swain, MD 110 Irving St., N.W. Wash., D.C. 20010 31. Date filed (Month, Day, Year) 1 1 2010 MAY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MAWZIAAGA CHINNA 17:15 MM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Howard Columbia If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 12 M 2□F Months Days Hours Min Yrs 196-42-9867 62 India April 07.1948 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 👿 No Director Howard Ellicott City Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4600 Willowgrove Drive 21042 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 [X] No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by Specify: Asian Indian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Agricultural Meteorologist Federal Government 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Chinniah Doraiswamu Grace Sarojini Chinnappa ျှ 19a. Informant's Name/Relationship (Type. Print) Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sundari Christine Doraiswamy, 4600 Willowgrove Dr., Ellicott City, ND 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery |05/14/2010 |Ellicott City, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, M0124 11800 New Hampshire Ave.. Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL ノルデイとCJINN disease or condition resulting in deeth) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): 68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Day 5 ☐ Other (specify) P.O.1 1 ☐ Yes 2 ☐ No 9 Unknown 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2.**≥**No hin 24 hours after death.

the Funeral Director: After this certific

upletely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10053051 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

Walter Fleming Atha, MD, 5755 Cedar Lane, Columbia, Maryland 21044

37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day}2010 Month May Catherine M. Duble 5:51 am 06 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5017 Tackbrooke Drive Olney Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Washington. 1 □ M 2 🗓 F Months Days Hours Min, 11/08/194 Director 213-56-1294 61 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕱 No Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 3500 Vintage Spring Terrace U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: and Mental Hygiene. If Yes, Give 3 - Widowed 4 - Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Loan Officer Mortgage Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Ahiouris Bessie Krithis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Valli Ruiz - Daughter 5017 Tackbrooke Drive, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or or 1

Burial 2

Cremation 3

Removal from State 4

Donation 5

Other (Specify) cemetery, crematory or other place, Gate of Heaven Cem. 05/11/2010 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Metastatic Pancreatic Carcinoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Disease or injury) Examine Dulii fo (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No Pregnant at time of death Year Yes g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Non Small Cell Lung Cancer 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perforn certificate ☐ Yes 2 🕱 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Daughter Home 10 1 🗌 Yes 2 🗓 No 4 Nursing Home 5 Residence 6 X Other (Spe 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Y Natural 5 Pending Accident 2 🗆 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD060335 May 7, 2010 Banner 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Bannen, MD. 18111 Prince Philip Drive, Olney, Maryland 20832 31. Date filed (Month, Day, Year) Registrar's Signature

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician 11 2010 18:49 PM 11)ai Gary N. Fox /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMOR ST. Agres Hospital None If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/29/1953 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1**⊠** M 2□ F 56 223-64-8000 VA Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Howard Ellicott City MD 10g. Citizen of What Country? 10e Street and Number Funeral 4706 Ribble Court 21043 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. Specify: δ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Social Security Systems Analyst of Health and Mental Hygie If item 27 is marked other or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucille Gibbs Richard Fox ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4706 Ribble Court Ellicott City, MD Cindy Fox - wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 05/15/2010 Hanover, MD Ardent Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 4112 Old Columbia Pike Ellicott City, MD 21043 M00845 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician)ay disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Day Pheomor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 🗌 No 3 Probably 4 ☑ Unknown iis certificate has been si director, page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 ho

To the Fune

completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2010 11124 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 MORRIS MD Baltimore, 900 Caton Ave MD 21229. 31. Date filed (Month, Day, Year) MAY 13 State gare Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 651 Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Adele FASIMPAUR Year May 9, 6:15 A.M 2010 Medical 4a. Facility Name (if not institution, give street and numb Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olnev Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Country) W York Months Days Hours Min. Mar. 20 Director 578-26-7764 87 New Usual Residence of Decedent 28a-f shov 10a, State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 🗆 Yes 2 🖔 No 10e. Street and Number 10f, Zip Code 'n 10g. Citizen of What Country? 23a Funeral 15310 Pine Orchard Drive #1-K 20906 United States items ; 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ Black, White, etc ō 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: white "natural", Specify: 3 🕅 Widowed 4 🗆 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Real Estate Development Elementary/Seconday (0-12) College (1-4 or 5+) and Management 0wner Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Brodie Mae Horowitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, and 2 s Health 27 Joseph Manchester, Son 12632 Billington Road, Silver Spring, MD permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 5 ☐ Other (Specify) Adas Israel Cong. Cemetery 05/11/10 Washington, DC 21. Signature of Funeral Servi Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Small Bowel Obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Sepsis Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ☐ Pregnant at time of death
☐ Unknown Month Day Year be detached the 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 🗗 No Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural s after dea. al Director: Afte 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, To the Hospital within 24 hours a To the Funeral L Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59414 11 May 9, 2010

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Rakhmanin, Vladimir 18101 Prince Philip Dr., Olney, Md

32. Registrar's Signature

Dr. /Rakhmanin, Vladimir

31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frendman 06:00AM ert ram MAY 2010 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death HUSPITAL CArroll Westminster Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🙀 M 2 🗆 F 92 Months Hours Sept. 17 1917 New York Director 108-14-6441 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Potomac Director 10d. Inside City Limits Md. Montgomery 1 Yes 2 XNo 10e. Street and Number 9113 Willow Pond Lane ò 10f. Zip Code or than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 20854 hours after death 12. Was Decedent Ever in WS I Armed Forces? 1 Ayes 2 No If Yes, Give IIS Aym 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc.
White 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: US Army Completed 3 W Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 72 (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Legal/ Law Lawyer Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Frances Meltzer permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve once. ပ Meltzer Morris J. Freedman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, Street 3113 Willow Pond Lane, Potomac, Ma. 20854 Debra Cowen / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Shalom Cemetery | May 10,2010 Washington, DC Signature of Funeral Soolice License 22. Name and Address of Facility Torchinsky Hebrew Funeral Tome 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Alzheimer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause Eter orderlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed tran and that initiated events resulting in death) Last Due to (or as a consequence of) ias been signed by the attending physician as Should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Ectopic pregnancy Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an in 24 hours after death.

the Funeral Director: After this certificate has be applied filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 1 🗌 Yes 2 No Other: 1 Ampatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pendina 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mi 0669321

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Memorial

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 06, Day 2010 Mehdi Ghazinoor-Naini Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9613 Newbridge Drive Potomac Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 🗱 M 2 🗆 F Days Months Hours Min Director 75 213-68-3372 Usual Residence of Decedent "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9613 Newbridge Drive 20854 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 🗶 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Doctor Psuchiatru Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Mohammed Ali Ghazinoor-Naini Khadijeh Baghayi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mehrnaz G. Naini - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parklawn Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Prostate Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): MEHD that initiated events resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical - NAINI IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 🗆 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, Completed GHAZINOO autopsv ☐ Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one)

9601 Newbridge Drive, Potomac, Maryland 20854 20c. Location - City or Town, State 05/08/2010 | Rockville, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between Onset and Death Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Dav Year To the Hospital or Attending Physician: The law requires that the derwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No **Division of Vital** 1 🗌 Yes Other: မ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation 1 🗌 Yes 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37891 May 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Rajvanshi, MD, 121 Congressional Lane, #409, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

Iran

1 ☐ Yes 2 🗓 No

10d. Inside City Limits

Caucasian

Montgomery

U.S.A.

Birthplace (State or Foreign Country)

8:37 am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}20<u>10</u> Physician/ MAY 09 **GLADYS** HOLZAPFEL В. 8:50A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1201-A WEST CENTRAL AVE. DAVIDSONVILLE ANNE ARUNDEL 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours octinth, 19 PENNSYLVANIA Director 228 78 7786 88 Usual Residence of Decedent show r than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARYLAND ANNE ARUNDEL DAVIDSONVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral WEST CENTRAL AVE. 21035 UNITED STATES 1201-A 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) HOMEMAKER HOME Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: I frem 27 is many injury or other. 2 GEORGE BLESSING HULDAH A. FOGARTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>VALENTINE G</u>. HOLZAPFEL (HUSBAND) 1201-A W. CENTRAL AVE. DAVIDSONVILLE, MD. 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State KALAS CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 05-11-2010 | EDGEWATER, MARYLAND 21. Signature of Funeral Service Li 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME SOLOMONS ISLAND ROAD EDGEWATER MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of: Examiner Sequentially list conditions, if any loading to minimal the cause. Enter Underlying Cause (Disease or iinjury Examiner Dile to for sels consequence of law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Division of Vital Records, P.O. Box 68760 as t the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death Day n signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed?

Yes 2 \(\subseteq \) No or Attending Physician: The this certificate 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Funeral Director: After upleted filled in by the funeral price to the funeral placed in the funeral placed filled in by the funeral placed filled filled in by the funeral placed filled f Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of Amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a, Certifiei Amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 Certifying Nurse Practioner: 5 29b. Signature 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcalus 3168 C . State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month Jessie Lee Hall 2ÖÎO 06:12 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 227 Brick Church Road Davidsonville 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 ⋤ F Hours Min. 05/17/1915 220-78-9500 94 Ma^G*Tand **Director** Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 10d. Inside City Limits Maryland Anne Arundel Davidsonville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 227 Brick Church Road 21035 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 ☐ Yes 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced If Yes, Give Completed Specify: White Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental } John E. Hooper Rosie L. William and is 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City of Town, State, Zip Code) 227 Brick Church Road, Davidsonville, Maryland 21035 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Linda J. Hall/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury 4 Donation 5 Other (Specify) 05/07/2010 Mary's Cemetery <u>Annapolis, Maryland</u> 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CHEDIAC disease or condition Medical resulting in death) Examiner ORONARY ARTEMY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the actual of the control of the Funeral Director. the burlal-transit HYIERTENSION Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 SB IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for Day Pregnant at time of death 5 Other (specify) Month Year g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certific 29d. Date signed (Month, Day, Year) oliver Lesso 1002513 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carol Pressey, 3168 Braverton St., #250, Edgewater, Maryland 21037

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

MAY 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 17, 2010 Medical Thomas Lawrence Houser 6:24 P M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital eonardtown Mary's Social Security Number 7. Age (In yrs. last birthday) Funeral If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 578-54-5594 1 😿 M 2 🗆 F Months Days Hours Washington, DC Director 68 11 Monta Day 927 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f Maryland St. Mary's Hollywood 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 24948 Sotterly Road 20636 United States items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedon. Armed Forces? 1 ☐ Yes 2 ▼ No or Black, White, etc 1 X Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White "natural". If Yes, Give Year or Dates 3 Divorced 4 Divorced Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Health and Mental Hygiene. tem 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Painter Painting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Milton M. Houser Pearl B. Pearson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Saunders/Sister 24948 Sotterly Rd., Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20c. Location - City or Town, State Department of Burial 2 Cremation 3 Removal from State 5-24-2010 4 Donation 5 ☐ Other (Specify) Suitland, MD salur of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., M00817 30195 Three Notch Rd., Charlotte Hall.MD 20622 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Orse and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner -ventnalar standstillming Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 1 Yes 2 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Robably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 sl 24a. Was an autopsy performe 1 Yes 2 No Yes Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) ည 1 🗌 Yes 2 X No Other: After this 1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? Accident Investigation 2 🗌 No completed filled in by the Sulcide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 24 hours a Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge within 2 only one sturred at the time, date and place, and due to the causes; and manner as stated 29b. Signatur

DHMH 17 Rev 7/2009

State Registrar echardtown Mr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 4, 20 Î o **Physician** 5:30 A M Lorraine Girard Hicks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges College Park 9601 51st Avenue If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Day, Year) 14.1956 Days Hours 1 □ M 2 🖺 F Washington, DC 54 217-72-2725 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State "natural", or items 23a or 28a-f show 1 AYes 2 No Directo College Park MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20740 United States 9601 51st Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. and 2 should be filed within 72 hours after aleath and Mental Hygiene. 1 ☐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗷 No Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Receptionist/Office Manager Construction 12 7 is marked other traumatic event, 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty Elizabeth McCloskey Thorton Raymond Powell ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trausonce. 51st Ave. College Park Maryland 20740 9601 James Hicks/Spouse 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2x Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 5/12/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Simple Tribute 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MO1463 1040 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediate Cause (Final **Physician** years Ovarian Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed I physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 5 ☐ Other (specify) P.0. been signed by the should be detached g \square Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 1 ☐ Yes 2 🕱 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 | Pending s after death.

I Director: Af 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in To the Hospital within 24 hours a To the Funeral I completely filled Hospital 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) signer (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year,

DHMH 17 Rev 1/2001

Gabriel B.7500 Hanover Parkway, #105 Greenbelt, MD 20770

Registrar's Signature

29d. Date

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 6, 2010 Day 1:18 p Honaker Allen Eugene Medical Town, or Location of Death **Dunkirk** 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 1360 Jewell Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days June 27, 1925 1 🕱 M 2 🗆 F 84 Virginia 236-32-2860 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State ed other than "natural", or Items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 No Dunkirk Maryland Calvert 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20754 USA Funeral 1360 Jewell Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕱 No Specify: If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, <u>th</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ocie Compton Roy Honaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1360 Jewell Road, Dunkirk, MD 20754 Donna Rice/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 10 2010 1 🖰 Burial 2 🗆 Cremation 3 🗆 Removal from State Parklawn Wenorial Park 4 Donation 5 Other (Specify) Rockville, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, . Signature of Funeral Service Lic. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final chemic Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner ()ISEGJE OVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No jo Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the a Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [호 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, Completed plnods 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s has autopsy performed 1 Yes 2 No this certificate 1 ☐ Yes 2 No Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2-2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes |2 After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: Alpmpleted filled in by the fu Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 🗆 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number ٩ 6/0 May 2010 ompleted cause of death (Item 23a) (Type, Print) 110 Hospital Road, #310, Prince Frederick, MD 20678 30. Name and address of person what David Tardio, MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 1 1 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ZOLO Physician/ 0250 C Marc Jackson May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of moruland medical Balitmore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country)
MARYLAND 1 🔀 M 2 🗆 F Months AUG 30 1958 51 213-68-1946 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 XYes 2 No MARYLAND PRINCE GEORGES BOWIE 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 13202 4TH STREET 20720 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No
If Yes, Give
Year or Dates. UNKNOWN Black, White, etc. ģ 1 X Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant, If item 27 is marked other than 'ury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) YOUTH COUNSELOR JUVENILE CORRECTIONAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOHN WATSON MARQUERITE CAROL MOOREHEAD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LESLIE RELIFORD / SISTER 1240 BATTERY DRIVE, HAVRE DE GRACE, MD 21078 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite any injury or ot crematory or other place, 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State MT. CALVARY UAME CFM 05/15/10 ABERDEEN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, 552 LEWIS STREET, HAVRE 1 the mode of dving, such as cardiac of respiratory are bma 21078 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Pulmmary embolism disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner stage renal Swauentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit Due to (or as a consequence of): arter and that initiated events resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? for Month Day Year Pregnant at time of death signed by the a Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Hypertensim 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death? Diabetes mellitus type 2 24a. Was an has page 2 autopsy performed' 5) Artem Disease, with CABG Yes 2 No 1 Yes 2 No Coronary 25. Was case referred to edical 26. Place of Death (Check only one) funeral director, Be examiner? 1 ☐ Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of nours after death.

neral Director; After the filled in by the funeral 28c. Injury at 28d. Describe how injury occurred 1 Natural Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number NP1 1336 30 10 129d Date signed (Month, Day, Year) 29b. Signature and title of certifier 1336301019 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pat 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MFND#23aT+TIperMD, 5/12/10, BW, MCC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jaffe May 7, Physician/ Irving 2010 410 PM M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery 5225 Pooks Hill Road #401S Bethesda 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 XM 2 □ F Months Days Hours Min. Rhode Director 96 Island 213-14-9150 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State Examiner must be notified at Director FL. Palm Beach South Palm Beach 1 X Yes 2 No 10g. Citizen of What County,
United States 10e. Street and Number 10f. Zip Code 3520 South Ocean Blvd #F406 33480 **23**a Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black White etc. o. ò 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced "natural", Completed the Medical 16b. Kind of Business Industry Dry Cleaning Equipment and Supplies 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Sales Person Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Etta Cipkin David Jaffe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 9464 Newbridge Drive Potomac MD 20854 Stephen Jaffe - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/10/2010 Falls Church, VA David Mem. Gards Funeral Service Licenses 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc.
1170 Rockville Pike Rockville MD 20852 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or neart failure. List only one cause on each line. Chronic Renal Failure nterval Between Onset and Death Immediate Cause (Final Chronic / Acute Renal Failure -Pnysician/ disease or condition resulting in death) Medical Examiner Congestive Heart Failure Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to for as a consequence on Exami Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension physician and s the burial-trans Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Aortic Stenosis 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a. Was an autopsy has ☐ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6X Other (Specify) Summer residence Hospital Other: 1 Yes 2 X No To the Hospital or

within 24 hours after death.

To the Funeral Director: After this c 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1X Natural 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) May 8, 2010 D03792 s of person who completed cause of death (Item 23a) (Type, Print)
Oser 10301 Georgia Avenue #304 Silver Spring MD 20902 30. Name and address of person Irnest S. Oser. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:57 Physician/ OSKER MA MES Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) OF MARYLANDMEDILAL CENTER Examiner BALTIMORE 8. Date of Birth (Month, Day, Year) Mar. 17, 1931 9, Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Country)
Maryland Hours Min. **Funeral** 1 M 2 - F 79 213-30-2724 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show t0h County 10a. State filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director 1 Yes 2 X No Arnold Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA Funeral 21012 1489 Grandview Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black White etc. Armed Forces?

1 Yes 2 X No 1 Never Married 2 X Married White þ ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 If Yes, Give 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation traumatic event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Public Works Civil Engineer 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Elizabeth Kernan Virgil Kosker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arnold, MD 21012 1489 Grandview Road Geraldine Kosker / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) May 12, 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD Metro Crematory, INC. 4 Donation 5 Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licenses 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CerebrovASUSIAN DISEAS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examiner ng physician and as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death ase 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month in the past 12 months? for Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown cate has been signed by the page 2 should be detached g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 After this certificate has 26. Place of Death (Check only one) 25. Was case referred to medical the funeral director, Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death 1 Natural Certificate: work? 1 ☐ Yes 2 ☐ No Hospital or Attending 24 hours after death. 5 Pending M Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide
4 Homicide determined completed filled in by 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Under the cause (s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MAY emeth D. G. umban 24317 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

KENNETH D.

31. Date filed (Month, Day, Year)

MAY 11

SOUTH GREEN ST BALTIMORE MY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6 2<u>010</u> Month Physician/ MARY ELLEN KAVANAGH MAY 7:20 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 8. Date of Birth May 21, 1956 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 D M 2 🛛 F Months Days Hours Min. New York 53 **Director** 126-48-6661 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njurry or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No Shepherdstown W٧ Jefferson 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 25443 USA 4452 Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 19 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 1985-2003 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U S Army Medical Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mary Ellen Fitzgerald Edward Joseph Kavanagh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pershing Dr., Arlington, VA 22201 <u> Alice M. Kavanagh - Sister</u> 3311 Ν. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/11/2010 Shepherdstown, WV E1mwood Cemetery 22. Name and Address of Facility Eackles-Spencer & Norton Funeral 21. Signature of Funeral Service Licensee M00970 WV_{-} Home. Harpers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ METASTATIC BREAST CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 XNo Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? signed d be det þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No this certificate 2 **X**N Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 9900650 (NC) Marie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL NATIONAL NAVAL 10 BETHESDA MD 20889-5600

DHMH 17 Rev 7/2009

State

Registrar

COLLEEN DORRANCE

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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		-	Plea - State Registrar	Se Type or P State of I		d / Depa		Health and			2010) 16524
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Examiner 4a. Facility Name (if n				f not institution, give street and number)			4b. City, Town, or Location of Death Olney			4c. County of Dea		eath
	Funeral Director			6. Sex 7. /	7. Age (In yrs. last birthday) If U		If Under 1 Year If Under 24 Hrs. 8. Date of			f Birth 9. B		Sirthplace (State or Foreign
		tor	Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	cation					10d. Inside City Limits
RD	th the Mary 3a or 28a-f t be notifie	Funeral Director	MD Montg 10e. Street and Number 17216 Wellfleet		Olr	1ey	10f. Zip Code 20852				itizen of What (
\Q 9E0	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder	s? ⊠ No	- 1	Vas Decedent of I	Hispanic Origin? (S an, Mexican, Puer o Specify:	Specify Yes or No- to Rican, etc.)	<u> </u>		nerican Indian,
215-0	in 72 hour e. ian "natu Medical	Completed	15. Decedent (Specify only highes Elementary/Seconday (0-12)	's Education t grade completed) College (1-4 of	or 5+)	(Give I	lent's Usual Occu kind of work done O NOT use retired	during most of wo	rking	16b. l	Kind of Busines	s Industry
Baltimore, Maryland 21215-0036	be filed withi antal Hygien ked other th c event, the	To Be Co	17. Father's Name (First, Middle, La Heinrich Skapow	4 st)		Voice	e Coach	18. Mother's Na	me (First, Middle	_	Sumame)	
, Maryl	d 2 should talth and Me 27 is mark		19a. Informant's Name/Relationship (Type, Print) Regina Kern-Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17216 Wellfleet Drive Olney, MD 20832									
timore	t. Page 1 ar tment of He tant: If iter ijury or oth		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (Sp		to Co	emetery, cren cional	sition (Name of natory or other pla Cremato	ry [05/]	Date 1/2010	Fal	ocation - City o	ch, VA
Bal	permit Depar Impor any in		21. Signature of Funeral Service Li	ensee N	10116	う ²²	Name and Address 100 Roc	ess of FacilityEdv 1 Rockvi 2kville,	rard Sag MD 2085	el F 2	uneral	Direction,
	Physician/ Medical		23a. Part 1. Enter the disease, or of shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ly one cause on each I Non-H	ine.	n's Lyr		ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death About 5 year
90	that the death certificate be e. ned by the attending physiciar i detached for use as the burit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): d.									
. Box 6876(by Physician/Medic	in the past 12 months?						23d. Date of d Month	lelivery Day Year		
ls, P.O.		ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4									
Λ = E ≅ E								24a. Was auto perfe 1 \(\sum \) Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of	
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on of \			27. Manner of Death 1 X Natural 5 Pending 2 Accident Investige	28a. Date of ir (Month, L	npatient 2 LI EN/Outpatient 3 LI DOA 4 LI Nursing Home 5 K			Residence 6 □ Other (Specify) escribe how injury occurred				
Divisio	To the Hospital or Attending PP within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral	al Certif	3 Suicide 6 Could n 4 Homicide determin	determined 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and City or Town, State)					Number or Rural Route Number,			
	the Hospifiin 24 hours he Funerappleted fill	Medical	(Check 2 L Medical Ex	Physician: To the best aminer: On the basis of lurse Practioner: To the	f examination	and/or invest	igation, in my opini	on, death occurred	at the time, date a	and place	e, and due to the	e cause(s) and manner stated
	Nith To t		29b. Signature and title of certifier	29c. License number D37888 29d. Date signed (Month, Day, Year) May 8, 2010				th, Day, Year)				
			30. Name and address of person w					124Ъ. 900	00 Rockv	ille	Pk. Ro	20892 ockville,MD
r	Stat Registra	e	31. Date filed (Month, Day, Year)	10 82. Regis	trar's Signatu	ure And	w					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 01:15 AM May Michael Francis Laporta Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 5051 Turkey Point Road North East If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days (Month, Day, Year, Coungwracuse New York Min. 1 XM 2 □ F Director 74 A110 082-26-8798 Usual Residence of Decedent 28a-f show 10d Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State Director 1 Yes 2 XNo North East Ceci1 Marvland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21901 5051 Turkey Point Road death \ 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 X Married Completed by 72 hours after Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify. Specify: than "natural", 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Leasing 4 President marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Katherine Margiasso Michael Laporta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 1 and 2 s of Health item 27 Turkey Point Road, North East, Maryland 21901 <u> Marjorie Laporta / Spouse</u> Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any Injury or ot Page 1 Safeneter Rose of cherniace Cemetery Typurial 2 Cremation 3 Removal from State Chesapeake City, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign wire of Funeral Service Vicensee Crouch Funeral Home 22. Name and Address of Facility 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final MINKMOUN Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of anding physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? ξō Month Year Day 2 No is certificate has been signed by the director, page 2 should be detached 9 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director: After this certificate has b performe 1 🗌 Yes 2 🗷 No Yes 2 X N Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2' No ၉ 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ▶ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: **A**Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier C1000 7506 30. Name and address of person who completed cause of reath (Item 23a) (Type, Print) Dr. Hector E. Sanchez, 7 & Clayton, Wilmington, Delaware 19801 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ralph Douglas Lee Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8204 Clay Drive Fort Washington Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 1 M 2 F Months Min **Director** Country 579-76-8732 52 Washington DC 16 Usual Residence of Decedent ms 23a or 28a-f show must be notified at and 2 should be filed within 72 hours after death with the Manyland Health and Mental Hygiene. Health and Mental Hygiene. 25 ar 28a-f show the traumatic event, the Medical Examiner must be notified at the fraumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ₹ Yes 2 No Marvland Prince George's Fort Washington 10e. Street and Number 10g. Citizen of What Country? Funeral 8204 Clay Drive 20744 United States Was Decedent Ever in U.S.UNK
 I3. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces?
 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces? ģ 1 X Never Married 2 Married Black White etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Pharmacist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph Turner Lee Rachel Jasper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Rachel Phillips/Mother Fort Washington, Maryland 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) May 11, 2010 Laurel, Maryland 4 Donation 5 Other (Specify) Maryland National Signature of/Funeral Sentice 22. Name and Address of Facility McGuire Services, Inc. 7400 Georgia Avenue, NW Washington, DC 20012 23a. Part 1. Enter the diseasel or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ 5 Years disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertension, Hyperlipidemia, Manic Depressive Disorder Completed 1 X Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2: autopsy performed? death? Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ၉ 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) hours after death.

neral Director: After the filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760 To the Hospital o within 24 hours af To the Funeral Di completed filled in

DHMH 17 Rev 7/2009

Norman Smith

31. Date filed (Month, Day, Year

(Check

29b. Signature a

tioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day, Year,

May 10, 2010

29c. License numbe

D41240

Certifying Nurse Prag

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Z D \ C Month 900 **Physician** seon /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Annapolis 2700 Summerview Way Unit 301 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 6/6/1932 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral New York Days Months 1 X M 2 ☐ F 115-24-5748 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location Maryland Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygene. and the firem 27 is marked other than "natural", or Items 23a or 28a-f show ant. If item 27 is marked other than "natural", or Items 24a or 28a-f show any or other traumatic event, Ite Medical Exprine. Annapolis Anné Arundel 1 ☐ Yes 2 🛂 No Director 10a. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 2700 Summerview Way Unit 301 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 A Married Baltimore, Maryland 21215-0036 1∐Yes 2. ANo Specify: White 50-54 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Quality Control Engineer 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Marie Dolores Donnelly Joseph George Lutzel ပ္ 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 2700 Summerview Way Unit 301, Annapolis, MD 21401 19a. Informant's Name/Relationship (Type. Print) Holly Hoebreckx - Wife 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or one. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Crematory 5/15/2010 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Signature of Funeral Service Licenses Muselin T. Bobat 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TONI Lanctr disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Tilnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) Nursing Home SX Residence 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 110110 065272 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1915 ruggina RUSUX 300 1670 31. Date filed (Month, State 11 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 P^{M} Mary Lenora Mayo May 80 1:45 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Maryland 1 🗆 M 2 💢 F 69 Hours Min. (Month, Day, 214-38-1728 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d, Inside City Limits 10a. State within 72 hours after death with the Maryland ems 23a or 28a-f sh r must be notified a Funeral Director Arnold MD Anne Arundel 1 Tes 2 No 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? USA 982 Shore Acres Road 21012 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. or Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) nd Mental | marked c မ Margaret Lamdin Spencer C. Jones 1 and 2 should be of Health and Me item 27 is mark 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 982 Shore Acres Road Arnold, MD 21012 Howard Mayo / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o May 12 2010 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Memorial Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S ice Licensee 22. Name and Add Barranco ress of Facility & Sons , Severna Park Funeral Home P.A. 495 Gov. Ritchie Hwy, Severna Park, 23a. Part 1. Enter the disease shock, or heart failure. Lis δ r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) for as a consequence of: **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last as the burial-transit Due to (or as a consequence of): attending physiciar Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) Day Year ate has been signed by the page 2 should be detached g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has performed 2 🗌 No 1 Yes Yes 2 filled in by the funeral director, Be Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending death. 1 🗌 Yes 2 No Accident Suicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one 29b. Signature and title 29d. Date signed (Month Day, Year) on who completed cause of death (Item 23a) (Type, Print) 30. Name and 31. Date filed (Month, Day, Year, 32. Redistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:59A Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Days 0172871920 1 M 2 M F 90 Washington DC 214-10-4755 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or Items 23a or 28a-f sho edical Examiner must be notified at Director Stevensville MD Oueen Anne 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21666 618 Bayside Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 X Never Married 2 Married 1 Yes 2 NowII White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 Widowed 4 Divorced Year or Dates. ntal Hygiene. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Management Analyst Foreign Service College (1-4 or 5+) 04 Elementary/Seconday (0-12) is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ပ Daisy McCusker Ephraim R. Miller other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 Bayside Drive Stevensville, MD 21666 19a. Informant's Name/Relationship (Type, Print) Personal Rep Jacquelyn Honeck 1 and 2 s of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Page 1 a Department of H Important: If ite 5 1 Durial 2 X Cremation 3 Removal from State 05/07/2010 Glen Burnie, MD Atlantic Crematory injury 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Hardesty Funeral Home P.A. Annapolis, MD 21401 Saly 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MONTHS Immediate Cause (Final Physician/ disease or condition resulting in death) STAGE Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant a
9 Unknown Pregnant at time of death signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, s been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe 1 ☐ Yes 2 ☐ No this certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifications and present the security of the second of t 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) funeral director, Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 **N**O ၉ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 2 🗆 No 2 Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 To the F only one) 29b. Signature and title of certif State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MCKAY Physician/ Month May CECILIA 2010 7:30 a. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 F Hours 81 0770971928 Pennsylvania 199-20-0226 **Director** Usual Residence of Decedent 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Tes 2 No St. Mary's **Hollywood** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25338 Three Notch Road 20636 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education المالية ورام filed with. عال Hygiene. معتد than "r" 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pilot Michael Stepanik Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48132 Post Oak Rd., Cindy Young/Daughter St. Inigoes, MD 20684 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any Injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/19/2010 Mechanicsville, MD Mt. Zion Methodist 21. Semanting Septe Librage Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 Jr. M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LESMATURY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury CMNOMIC OBSTRUCTIVE PURLOWMY DIFFORE that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year signed by the a 1 ☐ Yes ∠ ∈ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MBALLA IIM Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 7 death? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes မ 1 Propatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) : After this e funeral o 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural thours after death. uneral Director; Afted filled in by the fun 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours e Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of cortiner 29d. Date signed (Month, Day, Year) 29c. License number D1609C

opmo-

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5,

Cribe

LEONAN TOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month ROBERT **EUGENE** MAGIN 8:15 Рм May 6, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House - Montgomery Hospice Montgomery Derwood If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Months Sept. Day 2 (Par) 1970 218-88-1621 39 Maryland Director Usual Residence of Decedent rral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Montgomery 01ney 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18812 Bloomfield Road 20832 United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ☐ Yes 2 🕅 No If Yes, Give ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. White "natural" 3 Widowed 4 Divorced Specify: Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) within 7 Elementary/Seconday (0-12) Marriott College (1-4 or 5+) Accountant it. Page 1 and 2 should be filed withi trment of Health and Mental Hygien rtant: If item 27 is marked other th njury or other traumatic event, the International Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ Edwin Eugene Magin Charlotte Virginia Osterhus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 18812 Bloomfield Rd. Olney, Maryland 20832 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau. once. Jennifer K. Magin (Wife) 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Alexandria, VA Metropolitan Crem. 4 Donation 5 Other (Specify) Signature of Funeral 22. Name and Address of Facility DeVol Funeral Home M00689 10 East Deer Park Dr. Gaithersburg, MD 20877 Part 1 parter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocky of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Anaplastic astrocytoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No for Day Year Pregnant at time of death be detached Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 X Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 1 Yes 2 No Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D60624 May 7, 2010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Bindu, M.D., 6001 Muncaster Mill Road, Derwood, MD 20855

State

Registrar

31. Date filed (Month, Day

2010

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:00 Рм Margaret Louise McIntyre May Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Oregon 1 M 2 X F Months Days Hours Min. (Month, Day, Year) 542-26-2176 Director 84 Sept 19 Usual Residence of Decedent and 2 should be filed within 72 hours and 2 should be filed within 72 hours and 2 should be filed within and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show items 27 is marked other than "natural". 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Bethesda 1 🗌 Yes 2 🙀 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8205 Lilly Stone Dr. 20817 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nutritionist P.G. Health Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Kehrli Mabel Louise Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Aberdeen Dr. Chapel Hill, North Carolina 27516 Karen Kingsolver/Daughter Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 Department of 1 Burial 2 Tremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Crematory 5/10/2010 Brentwood, Maryland Signature of Funeral Service Licensee M01463 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 23a. Part 1/ nte/thr disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heary failure. List only one cause on each line. Approximate shool, /r heart fail Interval Between Onset and Death Physician/ Diverticular Perforation disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Por 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s Jas autopsy performed? 1 Yes 2 X No Yes ours after death. eral Director: After this certific filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 😓 Other (Specify) Casey House 1 Yes 2 🔀 No ပ 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🛛 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 10 D0060634 5/3/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph 1160 Varnum St. #021; Washington, DC 20017

Registrar

31. Date filed (Month, Day, Year)

MAY

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 8:00p M Candida Anna Meyer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Brighton Gardens at Friendship Heights Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York Social Security Number 6. Sex 8. Date of Birth **Funeral** Hours 1 - M 2 V F 02/07/1915 **Director** 088-05-8779 95 Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Chevy Chase 1 X Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with U.S.A. 5555 Friendship Blvd., 20815 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 X No þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify. Completed 3 X Widowed 4 Divorced Caucasian Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Pattern Maker Garment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antonio D'Angelis Addolorata Paolucci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health a Mary Lou Egan - Trustee 4411 Westover Place, NW, Washington, DC 20016 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Donation 2 Cremation 3 X Removal from State 4 Donation 5 Donation 5 Riverside National 07/09/2010 Riverside, CA 22. Name and Address of Facility Hines-Rinalli Funeral Home, 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Hypertension 10 years Sequentially list conditions, Examine Due to for de a consecuence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown 2 X No P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 $\[\]$ Residence 6 \square Other (Specify, 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 06,2010 MD0060129 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brent Cole, MD, 5530 Wisconsin Avenue, #730, Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) 32 Registrar's Signat State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2010 Robert Stanley Morgan 7, 2:58 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ፟ M 2 ☐ F Days Months Hours Min June 12, 1954 55 Director 212-62-3128 Washington, DC Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Maryland Montgomery 1 Yes 2 No Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 433 West Side Drive, #301 20878 United States 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify. Year or Dates. Vietnam 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Land Surveyor Land Surveying Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Rebecca Burdette Robert Leon Morgan other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 433 West Side Drive, #301, Gaithersburg, MD 20878 Linda Pickett Morgan (Spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20c. Location - City or Town, State Date injury or 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State May 8, 2010 4 Donation 5 Other (Specify) Alexandria, Virginia Črematory 21. Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home, anyi J100689 10 East Deer Park Drive, Gaithersburg, MD 20877 inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, be the att failure. List only one cause on each line. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Euysician/ disease or condition resulting in death) a Small Cell Lung Cancer Months Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ending physician and use as the burial-transi that initiated events or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death the g Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ signe be c Chronic Obstructive Pulmonary Disease Division of Vital Records, 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease page 2 autopsy Diabetes 1 Yes 2 No ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Kinpatient 2 ER/Outpatient 3 DOA Other: မ 4 Nursing Home 5 Residence 6 Other (Specify, After this funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Pragioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D26540 May 7, 2010

Registrar
DHMH 17 Rev 7/2009

State

16220 Frederick Road, Gaithersburg, MD 20877

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32 Registrar's Signature

Schoenberger,

Carl I.

31. Date filed (Month, Day, Year

MAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 6535 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alton Wilbert Morris Month 2010 May 6, 2:26 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days July 26, Hours Min. 1 XM 2 | F 230-30-5024 78 Yrs Director VA Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No MD Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 412 Lincoln Avenue 20912 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 X No Specify. Completed 3 Divorced Year or Dates. 1952-54 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) 4 Manager Insurance Claims Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hezikiah Morris Amanda Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willa M. Morris/Wife 412 Lincoln Avenue, Takoma Park, MD 20912 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver 21. Signature of Funeral Service Licensee Chlumanism 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Cardion Onset and Death nd Physician/ 5545e Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and-trar Due to (or as a consequence of): resulting in death) Last the attending physician the dria Physician/Medical detached ģ signed I Completed by peen has Be မ

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral

•	■ d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23d. Date of delivery Month Day Year					
Part II. Other significant conditions	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 Unknown					
		24a. Was an autopsy gridings available prior to completion of cause of death? 1 □ Yes 2 □ No				
25. Was case referred to medical	26. Place of Death (Check only one)					
examiner?	Hospital: 1 Inpatient 2 R/Outpatient 3 DOA Other: 4 Nursing Home	g Home 5 Residence 6 Other (Specify)				
27. Manner of Death Natural 5 Pending Accident Investigation	injury work? M 1 Yes 2 No	d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						

29c. License number

52326

29d. Date signed (Month, Day, Year)

06

2010

DHMH 17 Rev 7/2009

State

Registrar

Certificate:

Medical

only one) 29b. Signature and title of certifier

Name and address

31. Date filed (Month,

James K. Lightfoot, MD

32, Registrar's Signature

course

cause of death (Item 23a) (Type, Print) 20010 Century Blwd., Germantown, MD 20874

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 8, 2010 6:44 a Donald M. Mutzabaugh M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Montgomery 15115 Interlachen Drive, #406 Silver Spring 5. Social Security Number Sex 1 M 2 G F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Pennsylvania oct. 29^{Pay,} 1915 217-44-0200 Director Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show is marked other than "natural". 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Tes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 20906 15115 Interlachen Drive, #406 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? ģ 1 Never Married 2 Married 1 ☐ Yes 2 H No Specify: If Yes, Give 1943-46 Specify: White 3 X Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ഉ Walter Mutzabaugh Anna Lehman 1 and 2 should b of Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print)
Gary D. Mutzabaugh/Son 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5037 Riverfront Drive, Suffolk, VA 23434 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott May II. cemetery, crematory or other place)
Fort Lincoln Cemetery 1 Burial 2 Cremation 3 Removal from State Brentwood, Maryland 4 Donation 5 her (Specify) 2010 ice Licens Francisd Jodge Sifiris Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxi*m*ate Interval Between Onset and Death Immediate Cause (Final Physician/ l week Cardiac Failure Medical resulting in death) Due to (or as a consequence of): Examiner 2 weeks Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last Interstitial Lung Fibrosis 2 years Due to (or as a consequence of) physician s the burial Physician/Medical 2 weeks Pneumonia IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Osteoporosis, Kyphosis 1 Tes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 K Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) amcoss Oly 125410 10, 2010 May 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oliver J. Lawless, MD 18111 Prince Philip Drive, Olney, MD 20832

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 5 per FH G904 6/9/10 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical County of Death 4b. City, Town, or Location of Death Facility Name (if not institution, give **Examiner** 9. Birthplace (State or Ford If Unde 8. Date of Birth **Funeral** 1 M 2 🗆 F None Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 2 No 3
Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done life. DO NOT use retire) (Specify only highest grade completed) nday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 193. Mailing Address (Street and Number or Rural Route Number, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ☐ Burial 2 Cremation 3 ☐ Removal from State Glen Burnie, MD 05/10/2010 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Furieral Service Linesee 22. Name and Address of Facility 12 Ridgely Annapolis, Hardesty Funeral Home P.A. 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between a, set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 2 No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 Yes After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25, Was case referred to medical examiner? 26. Place of Death (Check only one) **Division of Vital** Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗖 No 1 Yes 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA မ 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Arundel Medical Center Annapolis, MD 21401 ann 31. Date filed (Month, Day, Year) State 1 0 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 2010 Physician/ C. Richard Evalyn 2:20 p May 11 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, Examiner Montgomery Burtonsville Sanctuary at Holy Cross If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours 1 🗆 M 2 🎛 F **85** Aug. 13 578-24-5996 ^{Year}1924 D.C. Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Examiner must be notified at Director 1 Tes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō items 23a Funeral USA 20910 8915 1st Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 6 1 X Never Married 2 Married ð Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+ Federal Government 12 Assistant Be permit. Page 1 and 2 should be filed. Department of Health and Mental H-mportant: If item 27 is many injury or other filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Fannie Coffelt Harry Holt Richard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 6500 Rock Spring Drive, Suite 300, Bethesda, 19a. Informant's Name/Relationship (Type, Print) John Lane/Personal Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Zion Lutheran
Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1x Burial 2 Cremation 3 Removal from State May 14, 4 Donation 5 Other (Specify) Woodstock, Virginia 22. Name and Address of Facility ins Funeral Home Inc. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it Yes 2 1 Ves 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Vursing Home 5 Residence 6 Other (Specify) 2 🛂 No 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? iniury Natural 5 Pending ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0069829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Avenue, Suite 203. 2835 10 OVI. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 04:34P ^M Margaret Elizabeth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Hours 1 □ M 2 😾 F 92 Director 207-03-3658 1/03/1917 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examinar must hamolitical and any injury or other traumatic event, the Medical Examinar must hamolitical and any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 🗋 Yes 2 😾 No Maryland St. Mary's Charlotte Hall 10g. Citizen of What Country? 10e, Street and Number Funeral 20622 USA 37770 Mohawk Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Farmers Market Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Tobias Edith Wyman Erline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith M. Cotter/Daughter 37770 Mohawk Dr., Charlotte Hall, MD 20622 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crem. 05/17/2010 Charlotte Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home, PA M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ata disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of been signed by the attending physician should be detached for use as the burial. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performe death? Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No this certificate Yes 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ER/Outpatient 3 DOA Certificate: To 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 To the I only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 16540 State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician/ 2010 May 6 6:40 p Sonia Rappaport Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Casey House 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days Months Hours 1/07/1934 1 🗆 M 2 🔀 F Washington, 75 **Director** 578-46-4032 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1X Yes 2 No Maryland Bethesda Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20814 USA 5118 Wessling Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married ş Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No If Yes, Give Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien. Public Relations Public Relations Consultant 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ruth Kohner permit. Page 1 and 2 should be Department of Health and Men-Important; If item 27 is marke any injury or other traumatic o Joseph Sharlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5118 Wessling Lane, Bethesda, Maryland Michael Rappaport, son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Judean Memorial Gdns 05/10/2010 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) MOIL 21. Signature of Funeral Service Licensee DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. 20852 1170 Rockville Pike, Rockville, Maryland Par Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Chronic Obstructive Pulmonary Disorder disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No ed by the a detached f g 🗌 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy performed? 1 🗌 Yes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 2 X No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ᅆ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 \(\superstruct{\substruct{\sunstty}\sinct{\substruct{\substruct{\substruct{\substruct{\substruct{\subs 1 X Natural 5 Pending injury Investigation Accident 2 Accider
3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) May 7, 2010 D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph, 1160 Varnum St, Washington, DC 20017 31. Date filed (Month, Day, Year) 3. Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner D 02 8. Date of Birth (Month, Day, Year) 05/25/1916 9. Birthplace (State or Foreign Sex 5. Social Security Number . Age (In y **Funeral** Min 1 □ M 2 🕱 F 93 PA **Director** 160-28-9574 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show ar than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21045 9431 Bullring Lane Funeral within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Yes. Give Completed by 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if then 27 is marked other than "na any injury or other traumatic event once." Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche French Richard Timmins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21045 Eleanor M. Foschetti - dau. Columbia, MD 9431 Bullring Lane 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 K Removal from State 05/18/2010 Beaver Falls, PA Beaver Falls Cem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licensee MO1411 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. El ter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final the roscherate **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2.☐No ed by the 9 Unknown 9 Unknown icate has been signed by , page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 8 3 Probably 4 Unknown 1 ☐ Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☑ No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

3

State Registrar Name and address

31. Date filed (Month)

of person who completed cause of death (Item 23a) (Type, Pri

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sue C. Schellenberg May 4. РМ 8:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Catonsville Commons Catonsville Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Washington, DC Director 80 577-34-3299 Usual Residence of Decedent show 10a. State 10b. County ms 23a or 28a-f sho must be notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1542 Themes Drive 21035 USA items :al Hygiene. •d other than "natural", or item: event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify. Completed 3 - Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be a Department of Health and Mental Important: If item 27 is meany injury or other? and Mental I ပ Carroll Mack Margaret Soo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Ann Fye/ Daughter 1542 Themes Drive, Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 5/5/10 Edgewater, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dving, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on mach line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death by the P.O. significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? ģ þe CHARLA IOVASCULAR Division of Vital Records, The law requires Completed 1 Yes 2 No 3 Probably 4 ☐ Unknown DeRTOUSION 24a. Was an 24b. Were autopsy findings available has autopsy performed prior to completion of cause of death?

1 Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2. No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident
☐ Suicide
☐ Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAY 1 2010

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 05/03/2010 CHARLES HENRY STEWART, JR. Medical 10:15 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Village Heath Care Center Montgomery Village Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 1X M 2 □ F (Month, Day, Year) 03/24/1938 **Director** 218-34-6064 Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits 1 XYes 2 □ No MD Montgomerv Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1135 University Blvd. W, #1102 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 X Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", Completed 3 Divorced 4 Divorced Specify: Year or Dates Black the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Truck Driver Parker Paving Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. Charles H. Stewart Rachael Virginia Prather 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Brown - sister Dalamar Street, #1, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Commation 3 Removal from St Ardent Cremation Svc : Hanover, MD 4 Donation 5 Other (Specify) 5/5/10 21. Signature Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one gain ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between use on each line. Immediate Cause (Final Ph sician/ Ma Onset and Death disease or condition Medical resulting in death) Due to (or as a cor Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a c and Due to (or as a consequence of) resulting in death) Last burialng physician a Physician/Medical that the death certificate be Box 68760 attending | IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown 2 🗌 No ed by the g Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed irector, p. ge 2 should be def 23e. Did tobacco use contribute to the cause of death? ρ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death.

Of the Funeral Director: After this certificate has the completed filled in by the funeral director, pige 2 s. autopsy performed? Yes 2 No 24 hours after death.
Funeral Director: After this certificeted filled in by the funeral director, i Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Original Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature ifier 29c. License number

State Registrar

Ahmed Hesmat

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0057574

10301 Georgia Avenue, #203, Silver Spring, MD 20902

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 26 per DVR G904 6/2/10 dk
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 7:33 PM Dorothy Stickell 2010 Mary May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Callaway Hospice House If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 17, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min 1 □ M 2 🖺 F Months Hours 88 Yrs 216-10-9309 July 1921 District of Columbi Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d Inside City Limits 10a. State Director 1 Yes 2 X No Leonardtown St. Mary's Maryland 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? ō Examiner must be Funeral 23a within 72 hours after death with 20650 24290 Pin Cushion Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or 1 Never Married 2 Married 1 Yes If Yes, Give ģ 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) US Census Bureau Statistician **12** injury or other traumatic event, 1 Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leslie "NMN" Dix Alice Smith of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24290 Pin Cushion Road, Leonardtown, MD 20650 Page 1 and 2 Carrol Edward Stickell Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date permit. Page 1 a
Department of H
Important; If ite 1 X Burial 2 Cremation 3 Removal from State May 19, 2010 Washington National Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 Signature of Funeral Service Licensee any Uchaelk 23a. Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ship ck, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Pregnant at time of death ed by the a detached f Records, P.O. that the s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed certificate 1 Yes 2 No 2 Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) hospice 2 XNo ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. this 27 Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) 12 pme Schmidt, DO. 40900 Merchants Lane Ste 250, Leonardtown, MD 20650 Jennifer M. 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 17 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 4:32 **Physician** SACHICO THRASHER 2010 May 5 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Heartland Health Care Adelphi Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2 🛣 F 75 March 29,1935 220-56-7442 <u>Japan</u> Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County ral", or items 23a or 28a-f shore Examinar must be notified at 1 ☐ Yes 2 ☑ No **Funeral Director** Kengsington Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Worden Exact near out being once. 4004 Denfeld Avenue 20895 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify. Specify: Asian þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hote1 12 Facilities Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unk ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4004 Denfeld Ave. Kensington, MD 20895 Peter Thrasher, Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 5/12/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee M01463 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. oner the drease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of her if failure. List only one cause on each line.

Immediate cause Pinal Approximate Interval Between Onset and Death diseax Levo Sclevotic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ere 5vo Vascular attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 5 Other (specify) □Yes 2□No 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28b. Time of Injury eral Director: After th filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 🖯 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P 0060600

Registrar
DHMH 17 Rev 1/2001

State

Attmins

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AHMZD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BLVD

Sart

Registrar's Signature

Univer 4

31. Date filed (Month, Day, Year)

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	Physicia Medic Examin	an/	1. Decedent's Name (First, Middle, Last) Ernesto Carlos Tono					2. Date of Dea Month May 6,						ay Year	3. Time of Dea 9:15 P	th M
		cal	THE SECOND SECTION AND ADDRESS OF THE SECOND					4b. City, Town, or Location of Death						c. County of Dea	77.55	
		ner	Casey House-Mon			ice		_	wood	Location	0, 5000			Montgomery		
	Funeral	-	5. Social Security Number	6. Sex	7. Age	(In yrs. la	st birthday)	If Und	er 1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bi	rth	g. Birthplace (State or Foreign Country) Colombia		
	Director >	579-04-1640 47 Yrs.								Dec. 1	6,	1962 Co.				
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	ems arm	Funeral	11. Marital Status	12. Was D	ecedent E	ver in U.S	. 13. V	Vas Dec	edent of H	spanic Or	igin? (Spe	cify Yes or No		14. Race - Am	erican Indian,	
9	or it		1 ☐ Never Married 2 🗶 Ma	rried 1 🗌 Y	1 ☐ Yes 2 🕅 No If Yes, Give 1 Year or Dates.							Rican, etc.)		Black, Wh		
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ylaı	ld be Menti arked atic e	입	Augusto Tono									Araujo				
Maryland 21215-0036	d 2 shou alth and 27 is m		19a. Informant's Name/Relation Paulina Angulo		e)		19b. Mailir 1250	ng Addre 9 Fa	ss (Street a	and Numb ridg	er or Rura e Dr	Route Numb	er, City o	or Town, State, 2	(ip Code) MD 20878	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other	n 3 ☐ Removal f	rom State	20b. PI	lace of Dispo emetery, crem Metrop Crem	sition (Nanatory or OI11	ame of other place an	e)		oate 3, 2010		Location - City o	r Town, State a, Virgini	a
Baltii	permit. F Departm Importa any inju		21. Signature of Juneral Service		\sum_{M00}		22	. Name a	and Addres	s of Facili			ner	al Home		
			23a. Fart 1. Enter the disease, of shock of beart failure. List	or complications the	nat caused	the death				_			_	<u> </u>	Approximate Interval Between Onset and Deat	n
	Physician/ Medical Examiner		Immediate Cause Final disease or condition resulting in death)	a	tasta to (or as a		Pancre ence of):	atic	Ade	nocar	cinor	na				
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В	executed an and rial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. — Due	to (or as a	consequ	ence of):									
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 🗌 F	, outcome Live Birth Pregnant at Unknown	2 🗌 Fetal	Ideath 3	Ectopi		У				23d. Date of d Month	elivery Day Year	
P.O.	that the led by t detack		Part II. Other significant condit	ions contributing	to death b	ut not resu	ulting in the ι	ınderlyin	g cause giv	en in Part	t I.	23e. Did	tobacco	use contribute	to the cause of death	?
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Division of Vital Records,	fhe law re ate has be bage 2 sh	Completed by								-		24a. Was auto peri 1 Yes	opsy ormed?	prior to death?	utopsy findings avail completion of cause es 2 No	able of
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of Vil	ng Physic ter this conneral dire	2	1 Yes 2 No 27. Manner of Death	28a. D	I Inpation Inpa	у	ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 🕱 Other (S 28b. Time of injury work? 28d. Describe how injury occurred							ecify) Hospic	e	
rision	r Attendir er death. rector: Af by the fu	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)					M 1 🗆 Yes 2 🗆 No						treet and Number or Rural Route Number,		
Ö	pital or burs aft eral Dir filled in	calC	29a. Certifier 1 X Certifyin	ng Physician: To t				nccured	at the time	date and	I place an				tated.	
	ne Hos n 24 ho ne Fun pleted	Medical	(Check 2 Medical	Examiner: On the By Nurse Praction	hasis of e	camination	and/or inves	tigation, i	n my opinie	on, death c	occurred at	the time, date	and place	ce, and due to the	e cause(s) and manner	stated
	vithi Vote		29b. Signature and title of certifi	er				2	9c. Licens	e number				ate signed (Mor		
	16		Bol	2	•				D60	524			Ma	y 7, 20	10	
	, -		30. Name and address of person Joseph Bindu,						Road	Der	hoow	MD 20	855			
	Sta		31. Date filed (Month, Day, Year)				ure Jan		Loau	Del	#50d	٠ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ				
	Registr	ar	MAY 11	2010	we will	p.	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:50am Nhien Xa Truong May Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2208 Greenery Lane, #102 Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) China 1 X M 2 □ F Days Months Hours 0972271926 Director 579-02-4421 83 Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 2208 Greenery Lane, #102 u.s.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates. 1 Never Married 2 X Married δ 1 ☐ Yes 2 No Specify: Specify: Asian 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Clock Repair & Elementary/Seconday (0-12) College (1-4 or 5+) Clocksmith Manufacture 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Truong Yip Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chau Ly - Spouse #102, Silver Spring, MD 20906 2208 Greenery Lane, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cem. 05/08/2010 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ perator disease or condition resulting in death) Medical Due to (r as a consequence of End stage Examiner Linkno Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 5 Other (specify) ed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed abetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops perform Yes 2 1 🗌 Yes 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) 1 Yes 2 **X**No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the with n To the 29b. Signature and title of certifier Williams, M.D State Registrar

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aurelia Wedderburn Mayonth 8^{Day} 20 YU 5:53 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Community Hospital George's . Age (In yrs. last birthday) Funeral If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 080-42-8030 1 □ M 2 🗓 F Months Days Hours Min (Month, Day, Year 2-03-195 Director Panama Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "nature" any injury or other traumatic events. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Mt. Rainier 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3105 Bunker Hill Road 20712 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian þ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give 1 Yes 2 No 3 Widowed 4 Divorced Specify. Specify: Black Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker Public Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leonard George Wedderburn Pauline Eunice Callender 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia A Coney (Sister) 3105 Bunker Hill Rd Mt. Rainier, MD 20712 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 5/15/2010 Brentwood, MD 21. Signature of Funeral Savio 22. Name and Address of Facility Fort Lincoln Funeral Home Lanc 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. Ist only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a core Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (a) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a co Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Pregnant at time of death Month Day signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by certificate has been si rector, page 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an autonsv performed? To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 **/**No မ 1 Tes 2 ER/Outpatient 3 DOA Nnpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending injury Investigation 1 🗌 Yes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and magner as stated within 2 To the only one) 29b. Signature and title 29d. Date sig ed (Month, Day, Year)

State Registrar ho completed cause of death (Item 23a) (Type, Print)

32. Registrar's

1 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>10:</u>58 A™ Patricia Α. Wentworth 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Bowie 12621 Chanler Lane 9. Birthplace (State or Foreign Country) Europe Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** Hours Months Days 1 □ M 2 🔀 F Month, Day, Year, 10/15/45 64 **Director** 099-66-7811 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 XYes 2 No Bowie MD Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral uid be filed within 72 hours after death with Mental Hygiene. aarked other than "natural", or items 23a natic event, the Medical Examiner must b 20715 USA 12621 Chanler Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 🔽 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) United Press Elementary/Seconday (0-12) College (1-4 or 5+) Executive Assistant 12 International other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) thent of Health and Mental Health and Mental Health and Mental Hant: If item 27 is marked of မ Marie Beddow Joseph Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Wentworth / Husband Bowie, MD 12621 Chanler Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ò ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any injury or Fort Lincoln Cemetery 5/15/2010 Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral . Signature of Funeral Service Licensee 20722 3401 Bladensburg Rd. Brentwood, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure/List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Manie disease or condition resulting in death) Medical Due to (or as a cor **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) as the burial-transi that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? for Month Day Year Pregnant at time of death the detached 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, s been significant Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify 2 No To the Hospital or Attending Prysis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. မ ER/Outpatient 3 DOA 1 Inpatient 2 I After this 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending ☑ Natural work' 2 🗌 No 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

Vinnie Juneja, MD 31. Date filed (Month, Day, Year) MAY 1 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6420 Rockledge Dr. Ste 4100 32. Registra s Signa

Medical

29a. Certifier

(Check

only one) 29b. Signature and title of of

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, it my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 0066990

Bethesda, MD

29d. Date signed (Month, Day, Year)

20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May 20 jg Physician 2:20 A M Thomas D. Williamson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harundale Anne Arundel 1300 Tarrant 5. Social Security Number Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 10 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) Months 172 M 2 □ F 217-52-4773 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Director Maryland Anne Arundel Harundale 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21061 USA 1300 Tarrant Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 🛣 o Specify. Specify: Black 3 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Hunt Robert W. Williamson ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8354 Catherine Ave Pasadena, Md. 21122 Lillie Henson(Sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Severna Park, Md. Carpenter Hill 5 - 13 - 104 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee PATAName Prot Address of Rollisons Mortuary, P.A. Tarry 21401 821 West St. Annapolis, Md. 1, Been MOO483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Year in the past 12 months? 1 □Yes 2 □No 5 Other (specify) 9 | Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death

law requires that the death certificate be executed burial-transi and P.O. Box 68760, attending physician for use as the buria ed by the a s been signed b should be deta Division of Vital Records, has page 2 certificate director, this funeral After e Hospital or Attendi 124 hours after death. e Funeral Director: A letely filled in by the fu death.

Funeral

Director

28a-f show

Tis marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examinat rust be routhed at

d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traun

Physician

/Medical Examiner

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Certification: To

1 Natural

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a, Certifier

Dá

5 Pending investigation 2 Accident 3 Suicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

erson who completed cause of death (Item 23a) (Type, Print)

leghway Sw Glin By mie MD2106/

29d. Date signed (Month, Day, Year)

State Registrar

Medical

DHMH 17 Rev 1/2001

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 5, 2010 Physician/ 6:10 p Marti Seitz Whitehead Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Arden Court Assisted Living Potamac 8. Date of Birth
(Month, Day, Year)
June 7, 1929 Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Hours Country) F**lorida** 255-34-4619 80 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 A No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20902 406 Hermleigh Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home traumatic event, fled \ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Howard Woodson Seitz Sarah Virginia Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Sowden/Daughter 406 Hermleigh Road, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 7 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State May Metropolitan Crematory 2010 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Aspiration Pneumonia Medical Due to (or as a consequence of) Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Due to (or as a consequence of) Examin Cause (Disease or iinjury Dementia that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 physician s the burial Physician/Medical law requires that the death certificate be Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s autopsy performed? Yes 2 A No prior to completion of cause of death? Hospital or Attending Physician; The 1 Yes 2 No this certificate Yes 26. Place of Death (Check only one) **Division of Vital** director, 25. Was case referred to medical Be examiner? ASSISCEO LIVING Hospital: Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Cther (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred in 24 hours after death.

the Funeral Director: After to a pleted filled in by the funeral Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and titia of certifie 29c. License number 05/06/2010 D35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Susan J. Miller, MD

31. Date filed (Month, Day,

Registrar's Signature

8218 Wisconsin Avenue, #305, Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra/MEND#14 penFH,5/21/10,BMW,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 12:45p Wansheng Wu May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number **Funeral** (Month, Day, Year, 03/25/193 Months Days Hours Min. 1 🕱 M 2 🗆 F Director China 577-06-7848 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 1040 Welsh Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. Asian þ 1 Never Married 2 x Married ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: ·White If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 6 Chef Restaurant Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H is marked o ည Yaopei Wu Xingai Zhao 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Astilbe Court, Centerville, VA Zisui Wu, son Baltimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Norbeck Memorial Park:05/ 12/2010 Olney, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Danzansky-Goldberg M 1170 Rockville Pike, Signature of Funeral Service Licensee Memorial Chapels, Inc. e, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Hemorrhagic Shock Medical Due to (or as a consequence of) **Examiner** Severe Sepsis Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examiner Due to (or as a consequence of) g physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Coagulopathy Due to (or as a consequence of): Physician/Medical Ischemic Bowel Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No signed by the a g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Respiratory Failure as been signals 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has, autopsy page , performed? this certificate 2 XN 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes ပ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending 1X Natural Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title D0055148 May 5, 2010 on who completed cause of death (Item 23a) (Type, Print)

State

Registrar

backer

1500 Forest Glen Road, Silver Spring, Maryland

Anglin,

2010

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 6, 2010 945 AM M Wo1k Shepard Herman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville 1139 Gaither Road 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Months Hours 1 ★ M 2 □ F May Year 1931 MASS'S'V) 78 027-24-9084 **Director** Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Rockville MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 20850 United States 1139 Gaither Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Pyes 2 Pyes 53

If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 |
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the MacAtonce. Elementary/Seconday (0-12) College (1-4 or 5+) Senior Historian U.S. Air Force Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Jennie Robinson Max Wolk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1139 Gaither Road Rockville MD 2085019a. Informant's Name/Relationship (Type, Print) Sandra Wolk - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Judean Mem. Gardens 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/09/2010 Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility M01163 oSagel Funeral Direction Inc Pike Rockville MD 20852 Edward 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ vears disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ or in the past 12 months? Day Year Month Pregnant at time of death ned by the a Yes q Unknown g 🗌 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 s autopsy perform death? performed? 1 Yes 2 No 25. Was case referred to medical **Division of Vital** director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 XNo 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) မ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier 1 各 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 3 29b. Signature and title of certifier To t $^{29\text{d. Date signed (Month, Day, Year)}}$ May 6 , 201029c. License number D54378 30. Name and address of person who completed ca se of death (Item 23a) (Type University Blvd West #400 Wheaton MD 20902 Cheryl Aylesworth MD 2730

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lan Shiow Yee May 5, 2010 Physician/ 1:01 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Village Health Care Center Montgomery Village Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Nov. 14, 1923 Hours Min. 220-80-3657 86 China Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland must be notified at Director 1 ☐ Yes 2 🌁 No Rockville Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 20853 TISA 13522 Grenoble Drive items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Force Black, White, etc. ò þ 1 Never Married 2X Married Yes 2 X No Baltimore, Maryland 21215-0036 Asian If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joe Wong Kim Ma traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14117 London Lane, Rockville, MD 20853 t of Health a Eddie G. Yee/Son other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō 1 🔀 Burial Cren 3 Ren al from 14, Department of Important: If any injury or once. Gate of Heaven Cemetery Silver Spring, Maryland 2010 4 Donatic 5 Other (Specify) Licensee 22. Name and Address of Facility Francis J. Colinas Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No ģ Year Pregnant at time of death detached 9 Unknown 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv certificate has page 2 2 X No 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, þ 4 Homicide determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the within To the 29b. Signature and title of certi-29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

10110 Molecular Drive.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anushiravan Dadgar, MD

31. Date filed (Month,

MAY

H51280

Rockville, MD 20850

May 7, 2010

			For State of Maryland 1- State Registrar		riment of H tificate of L			eg. No.	310			
ŀ			Decedent's Name (First, Middle, Last)		2. Date of Dear	th Day	Year	3. Time of Death				
	Physicia /Medic		Maurice S. Anderson, Jr.			May	22	2010	11:00P.M.			
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death		County of Death				
		\pm	Manor Care 5. Social Security Number 6. Sex 7. Age (In yrs. la	est hirthday)	Towson If Under 1 Year If Under 24 Hrs. 8, Date				Baltimore 9. Birthplace (State or Foreign			
i	Funeral Director		214–18–9080 11 M 2 F 87	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Jan • 24	,192.	3 Mar	y.land		
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	r 28a	irec	10e. Street and Number		10f. Zip Code		1	0g. Citize	n of What Co	untry?		
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	r dea	ne	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	i. 13. W	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	 Race - Ame Black, White 			
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Mever Married 2 Married 1 Mever Married 2 Married 1 Mever Married 2 Merried 1 Mever Mexicology 1 Mever Mexicology 1 Mex	1	□Yes ŽENo	Specify:		S	pecify: Bla	ack		
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	d be f	o Be	Morris S. Anderson, Sr.			Isabell	Smith					
2	should Me mark	2	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number or Rui	ral Route Numbe	r, City or T	Town, State, 2	Zip Code)		
M	nd 2 :		Carrie D. Banks/Sister	347 I	Eudowood	Lane Tows	son, Mary	land	21286			
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Vital	iclan: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. Place of Dea						
o 	hysic nis ce I direc	To E	1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatien		4 Lawursing H	ome 5 ☐ Resid			ecify)		
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200	tend leath. tor: /	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At ho	me farm str		Yes 2 □ No	28f Location (5	Street and	Number or F	Bural Route Number,		
DIVISION	al or A: after o I Direct d in by	Certification:	4 Homicide determined building, etc. (Specify									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	ledical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know and manner stated.	wledge, death ion and/or inv	n occurred at the ti vestigation, in my	me, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) a date and	and manner a place, and du	is stated. ie to the cause(s)		
)	To th within To th	Me	29b. Signature and title of certifier		29c. Licens	e number	24	29d. Date	signed (Mor	oth, Day, Year)		
	HV		30. Name and address of person who completed cause of death (Item	23a) (Type,	Print) ls (ane							
	Sta Registi		31. Date filed (Month, Day, Year) 32 legistrar's Signal MAY 27 2010	1. 60	ares							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 05:48 PM Aftanski Burton Garv MAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE OWSON SAINT JOSEPH MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6 Sex **Funeral** Days Hours 1 ★ M 2 □ F April 17, 1947 Queens' NY 63 40 9812 073 Director Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shortranmatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Baltimore City Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 5409 Creston Avenue 21214 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black White, etc. 1 Yes 2 No 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (124 or 5+) Elementary/Seconday (0-12) Barrett Business Services Safety Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Aftanski Margaret A. Ruff permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21214 Creston Avenue Catherine Y Aftanski 20a. Method of Disposition
1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State May 24 2010 Metro Crematory Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Lassahn Funeral Home Inc JESSOM 7401 Belair Rd Baltimore.Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition LIVER FAILURE Physician/ MONTHS Medical resulting in death) Due to (or as a consequence of) Examiner YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be as IF FEMALE nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ACUTE RENAL FAILURE 2 XNO Records, 3 Probably 4 Unknown Completed BYPASS SURGERY 24b. Were autopsy findings available prior to completion of cause of REMOTE GASTRIC 24a Was an autopsy performed: has MORBID 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending X Natural 5 Pending Division 1 Yes 2 No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05 12010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN R. AXE 7601 OSLER DRIVE TOWSON MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 27 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH, G904, 6/2/2010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Ye ar Physician Month 24 4:00 Kenneth L. Appell Mav 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 8925 Old Frederick Road Ellicott City
Under 1 Year | If Under 24 Hrs. Howard 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1⊠M 2□F $086 - \overline{15} - 9798$ Director 84 Sept. 13, 1925 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene, 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show "natural", or Items 23a or 28a-f show 1 □Yes 2 TX No Directo Maryland | Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8925 Old Frederick Road 21043 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ⊠Yes 2 □ No Black, White, etc. 1 ∑Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White <u>چ</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/ Operator Contracting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Walter Appelle Elsie Stayskill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Wife Anna B. Appell 8925 Old Frederick Road; Ellicott City, MD 21043 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ferncliff Cemetery 5/29/2010 Greenburgh, New York 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licens 630 Edmondson Avenue: Catonsville, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tipe. use on each the Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical e to (or as a quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2) No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer? certificate 2 🗆 No 1∏Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ê. 1 Yes 2 No Hospital: Other: 4 \(\sum \) Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) After this 27. Manner of Death 1 Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 5 Pending nours after death.
neral Director: Af
y filled in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/25/2010

Registrar
DHMH 17 Rev 1/2001

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

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		_1	State Registrar			Cer	tificate	of <u>C</u>	Death		Reg. No.	0 1 0	6559	
	Physicia	n/	Decedent's Name (First, Middle, Last)	Gail Prince			Armo	r		2. Date of Di Month May 20	Day	3. Time of Death 6:08 a M		
ر	Examiner 4a. Facility Name (if not institution, give street and number) Stella Maris						4b. City,		Location of Dea		4c. County of Death Baltimore			
	Funeral Director		5. Social Security Number 6. Sex 1 042–36–2013	e (In yrs. last t	birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min		irth 9. Birthplace (State or Foreign Country) 1945 NY				
	f show	tor	Usual Residence of Decedent 10a. State			own or Loc		Gait	hersburg				10d. Inside City Limits 1	
	h the Mary sa or 28a-1 be notifie		10e. Street and Number 8210 Pepperwood	21 #10	10f. Zip Code						10g. Citizen of What Cou USA			
36	te filed within 72 hours after death with the Maryland the Hygiene. Hygiene. Party and other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral		2. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S.	20877 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 □ Yes 2▼ No Specify:)- 1 ₄	I. Race - Ame Black, White pecify: Whi	e, etc.	
Maryland 21215-0036	in 72 hours e. nan "natura Medical E	Completed	15. Decedent's Edu (Specify only highest grad	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business Industry					
and 21	e filed within 7 ntal Hygiene. ed other than 8 event, the M	l os l	12 17. Father's Name (First, Middle, Last) Stephen William	1 Prince			Jewe]	ler		Sales / Services Name (First, Middle, Maiden Surname) 1th Clara Reich			ervices	
Maryk	ge 1 and 2 should be file nt of Health and Mental h :: If item 27 is marked o or other traumatic eve	i	19a. Informant's Name/Relationship (Typ Karen Armor Boods	e, Print)					and Number or R ner Way,				o Code)	
di.	Page 1 and ent of Heal nt: If item ry or other		20a. Method of Disposition 1 Burial 2 X Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	ceme	etery, cren	sition (Name	ther place		Date 27/2010	1	ation - City or		
Baltii	permit, Page 1 s Department of I Important: If ite any injury or ot once.		21. Signature of Funeral Service Ligense	Dorota Ma	arshal	1 22	2. Name an	d Addre	ss of Facility land Cre ox 1413.	mation :	Servic	es D 2120	3	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition									Approximate Interval Between Onset and Death					
المدا	Medical Examiner	J.	resulting in death) Due to (or as a consequence): Sequentially list conditions, b.											
	cate be executed physician and s the burial-transit	al Examiner												
Box 68760	ath certifi attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome	Sirth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ant at time of death 5 ☐ Other (specify)						23d. Date of delivery Month Day		*	
s, P.O.	requires that the de been signed by the should be detached	ğ	Part II. Other significant conditions con	tributing to death b	out not resultin	ng in the u	underlying	cause gi	ven in Part I.				the cause of death?	
of Vital Records,	sician: The law requ certificate has beer irector, page 2 shou	Completed						24a. Was an autopsy performe 1 Yes 2		prior to completion of cause of death?				
tai	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?	ospital:					lace of Death (Ch	eck only one)				
f Vi	Physic this cral dire	2	1 Yes 2 No	1 ☐ Inpat	ient 2 ER	/Outpatier		OA Oth	4 LT Nursing	Home 5 Res		•	ify)	
o L	ttending I death, ctor: After y the funer	icate	1 ☐ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Da		injury	М	work	k? I Yes 2 □ No					
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Il Certificate:									ral Route Number,			
ALL	Hospil 24 hour Funera	Medical		er: On the basis of e	examination an	nd/or inves	tigation, in	my opini	on, death occurre	d at the time, date	and place, a	and due to the	cause(s) and manner stated.	
5	To the within β	Σ	only one) 3 🔀 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the	Dest or my kn	iowieage,			e number	nace, and due to		signed (Monti		
			Jennell	May	CKI	N	>	51	5762	9	5	12612	010	
				mpleted gause of c					D075		WD 01	1000		
	Sta Registr		JENNIFER HAUF, C 31. Date filed (Month, Day, Year) MAY 27 20	RNP 2:	ar's Signature		VALI	JEY I	ROAD, TI	MONIÚM,	MD 21	093		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Maurice Eugene Blizzard 2010 5:05 AM May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster <u>Golden Living Center</u> 8. Date of Birth
(Month, Day, Year)
10/17/1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 - F **Director** 218-10-0359 89 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 🗌 No Westminster Carroll MD 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? Funeral USA 21157 334 Stoner Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Š 1 Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Divorced 4 Divorced White Completed Year or Dates. 1941-1945 nd Mental Hygiene. marked other than "natur matic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Utility Supervisor 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ it. Page 1 and 2 should be triment of Health and Mentartent: If item 27 is marked njury or other traumatic en Lydia Ellen Martin Jeremiah Blizzard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD 21157 Wife permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tronce. Stoner Ave. <u>Freda Mae Blizzard</u> 334 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/29/2010 Finksburg, MD Evergreen Mem. uneral Sarvice Licensee 22. Name and Address of Facility 21. Signatur 254 E. Main St. 21157 Westminster, MD Funeral Home 23a. Part 1. Ep ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi dunce and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant a
9 Unknown Pregnant at time of death be detached Unknown P.O. by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed' 1 Yes 2 No After this certificate Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural injury 5 Pending after death. 1 Yes Accident
Suicide Investigation the in 24 hous.

the Funeral Directory filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🜠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one d title of certifier 29b. Signatu cause of death (Item 23a) (Type, Print) 30. Name an DV filed (Month, Day, Year) 32. Reg State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Brun amantho Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tima 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland (Month, Day, Year) 1 🗆 M 2 😾 F Months Hours Min. 220-98-7141 36 Director 6,197 March 28a-f shov 10d. Inside City Limits 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 1415 W. Ostend Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: "natural", white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I hand Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) 5th College (1-4 or 5+) disabled disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel William Brown Anna Hoffman 1 and 2 should to the self had 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3616 6th Street, Baltimore MD 21225 Lisa Peightal-sister 20b. Place of Disposition (Name of cemeter, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Injury or Burial 2 X Cremation 3 Removal from State Department of Important: If 4 Other (Specify) May 29 2010 Glen Burnie MD Crematory ${\small \small \textbf{22. Name and Address of Facility}} \textbf{Ambrose Funeral Home of Lansdowne}$ Hammonds Ferry Road Lansdowne MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last requires that the death certificate be executed the burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) detached g Unknown 9 Unknown P.O. á 23e. Did tobacco use contribute to the cause of death? eral Director: After this certificate has been signed filled in by the funeral director, page 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Hospital or Attending Physician: The 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 **M**o Other: မ Inpatient 2 ER/Outpatient 3 [4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 - Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 24 hours after deatle Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 25 Year **Physician** 1. 5 AM 2010 05 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE ST AGINES HOSPITAL 8. Date of Birth (Month, Day, Year) 8-4-1936 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 439-52-4409 1**X** M 2□ F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinational to neithed at 1 XYes 2 □ No Director timore MT 10g. Citizen of What Country? 10e, Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Mayes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Su Father's Name (First, Middle, Last) Be ဂ 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code, 19a Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any injury or other trong. Jetterson 27 Iongala 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Pages ' 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ho. Nati Pike 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE PULMONARY DISEASE **Physician** MONTHS CHRONIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-trar Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? THO? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 12No 2 No 1 ☐ Yes 1 Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🛮 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier KESIDENT PHYSICIAN 05/25/2010 24060 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. CATON AVENUE, BALTIMORE, MD 21229 ASHOKA INDUKURI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.								
	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year May 17, 2010	3. Time of Death 1011 hrs						
(4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore	4c. County of	Death						
Director	5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min. July 18. Age (In yrs. last birthday) Yrs. Months Days Hours Min.		Birthplace (State or Foreign Country) Mary and						
11215-0036 If the filed within 72 hours after death with the Maryland Mental Hygiene. The filed other than "natural", or items 23a or 28a-f show any event, the Medical Examiner must be notified at once, o Be Completed by Funeral Director	10c. City, Town or Location 10c. City Town or Locati	Rican, etc.) White, Specify: work done 16b. Kind of Bus	American Indian, Black, etc. Black iness/Industry d States rmy wo be 11						
e, MD and 2 sho Health and item 27 is traumati	Down Method of Disposition Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Ave. Tulsa. Date 200. Location?	OKIAhoma City or Town, State Mills, MD						
Physician 2	3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. mmediate Cause (Final disease a. Complications of Intrabdominal Adhesions	ve. Balto. M	1.21216						
(xammer	Due to (or as a consequence of): Sequentially list conditions, b.								
amin (f any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated byents resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	- · · · · · · · · · · · · · · · · · · ·							
be executed be executed sician and urial - transit bdical Ex	d. UNPENDED AMENDED								
Box 6876(e death certificate the attending physed for use as the b hysician/Me	F FEMALE: 1b. Was decedent pregnant in the past 12 months? 1		Day Year						
Records, P.O. The law requires that it frate has been signed by, page 2 should be detach. Completed by F.	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	24a. Was an 24b. Was an autopsy pri de	ute to the cause of death? Probably 4 Unknown are autopsy findings available or to completion of cause of ath?						
tal Recol	5. Was case referred to medical 26.Place of Death (Check of De	1 ✓ Yes 2 No 1	Yes 2 No						
f Vitt	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing 7. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		Other:						
ion of tending Pheath. tor: After the funeral	(Month Day Year)	28d. Describe how injury occurred							
Division of Vital Rec spital or Attending Physician: The I cours after death. neral Director: After this certificate filled in by the funeral director, page Certification: To Be Con		28f. Location (Street and Number or Town, State)	or Rural Route Number, City						
Division To the Hospital or Attend within 24 hours after death To the Funeral Director completely filled in by the Medical Certification	Pa. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and conserved by Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.								
	9b. Signature and title of certifier 29c. License number O.C.M.E.	29d. Date signed May 18, 201	(Month, Day, Year)						
<u> </u>	Name and address of person who completed cause of death (item 23a) Carol Allan, MD	1							
State ³ Registrar	1. Date filed (Month, Day, Year) 32. Registrar's Signature 4. Save								

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Physicia		Registrar 1. Decedent's Name (First, Middle	Last)					2. Date of Dea		3. Time of Death	
ledical Exami	-	Alvin Nathanie						Month May 20, 2	Day Year 010	1317 hrs	
		4a. Facility Name (if not institution	-)]	4b. City, Town, o	r Location of D	eath	4c. County of Deal	th	
ď.		2100 Madison Street, A	·	4	t biath do N	Baltimore	ar If Under 24	Alles IO Date of Die	rth (MM/DD/YYYY) 9. Bi	irthniaca (Stato or	
Funeral Director		5. Social Security Number unit		je (In yrs. las		If Under 1 Yes		Min	Fore		
Director		218-44-8381 Usual Residence of Decedent	1 ^K M 2 F	63	Yrs			March	31, 1947 ^c		
any	ŀ	10a. State 10b. County		10c. City, 7	Town or Locat	on				10d. Inside City Limits	
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er dea	큔	3 Widowed 4 X Divo	X No	1	Yes 2 X No	o specify:		Specify: black			
1215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner	g P	15. Decedent's Education (Spec	or Dates:	mpleted)	16a. Deceden	t's Usual Occupa	ation (Give kind	of work done	16b. Kind of Business	/Industry	
5 72 ho ra "na	Completed	Elementary/Secondary (0-12)	5+)	· ·	ost of working life		e retired)		. 1.		
21215-0036 uld be filed within 7. Mental Hygiene. marked other than	ᇍ	12	0		site	manager		lame (First, Middle,	Ravens S	stadium	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	To B	19a. Informant's Name/Relationsh			19b. Mailing	Address (Stre	l et and Number	r or Rural Route Nur	mber, City or Town, Stat	e, Zip Code)	
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland tith and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at once		Carnell Baker	/brother		350	5 Beagle	e Lane .		andallstown		
re, l :1 and !Heali fitem er tra		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from St		lace of Dispos ematory or ot	ition (Name of ce ner place)	emetery,	Date	20c. Location - City of	r Town, State	
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Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thingury or other traumatic event, the Mes		21. Signature of Fun ral Service Ronald	water wir	ector	22.	ame and Addres	s of Facility a tomy	oard; 655	W. Baltim Orth Ave	ore Street	
	_ \	23a. Part I. Enter the disease, or o	11/000	the death.	Do not enter t	rch East				1202 Approximate Interval	
Physician	2 III	failure. List only one cause								Between Onset and Death	
Èxaminer		Imm to te Cause (Final disease or condition resulting in death)	Due to (or as a cons			case					
		Sequentially list conditions,	b								
	ine	if any, leading to immediate causs. Enter Underlying Cause	Cause								
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o, o, e be ex ysiciar burial		UNPENDED	23c. If yes, outco						23d. Date of delive	erv	
Box 68760, e death certificate be e the attending physicia ed for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ille of pregn		tal death 3	Ectopic pr	egnancy	Month	Day Year	
lox 6 eath cert e attendii	sicie			t time of dea	th 5 Ot	her (Specify)			İ		
that the de detached f	Phy	Part II. Other significant conditi	9 OHKIOWII	th but not re	sulting in the u	inderlying cause	given in Part I	. 23e. Did t	obacco use contribute t	o the cause of death?	
, P.O. res that t signed by		Liver Disease						1 ✔ Ye	s 2 No 3 Pro	obably 4 Unknown	
Division of Vital Records, tal or Attending Physician: The law requinr sher deer After this certificate has been siled in by the funeral director, page 2 should be	Completed by						_	24a. Was		autopsy findings available completion of cause of	
SCO! ne law te has ge 2 sl	ш			_		_		perfo	ormed? death?		
Vital Rec ysician: The l his certificate l director, page		25. Was case referred to medical	1			26.Plac	e of Death (Ch				
Vita hysicis this ce 1 direc	To Be	examiner? 1 ✓ Yes 2 No			ER/Outpatient				Residence 6 🗸 Oth	er: Scene	
n of \ ding Phy After th funeral		27. Manner of Death 1 ✓ Natural 5 □ Road	28a. Date of Inj (Month, Day,	ury Year)	28b. Time of		uryatWork? Yes 2 No		how injury occurred		
Sior Attend death ector:	catic	vrelia	tigation	niun/ At ho	me form stre	et, factory, office			Street and Number or F	Rural Route Number, City	
Division safer death al Director: led in by the	Certification:	deter	not be (Specify)	njury - At no	me, iaim, sire	et, ractory, office	building, etc.	or Town,		talai reate rambol, ony	
Divisior Hospital or Attenc 24 hours after death Funeral Director:		4 Homicide 29a. Certifier 1 Certifying Ph	ysician: To the best of n	ny knowledg	e, death occu	rred at the time,	date and place	, and due to the cau	se(s) and manner as sta	ated.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical		niner:On the basis of exa and manner stated								
E 2 E 2 S	Me	29b. Signature and title of certifie	2/1/	111	BOND		nse number		29d. Date signed (M	lonth, Day, Year)	
		Occlos &	alle	est -	7	0.0	S.M.E. 		May 21, 2010		
(3)		30. Name and address of person Victor Weedn MD JD	who completed cause of Assistant Medica			Penn Street,	Baltimore	MD 21201			
	tate	31. Date filed (Month, Day Year)	22. Registr	ar's Signatu		barke					
Regis		MAY	1 ZUIU LE	new	14. 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TICHAEL Month MAY 21 2010 8:35 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F (Month, Day 8-38-29 67 Country) Yrs. Director 2106 Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director PACE 1 Yes 2 No TARFOR 10e. Street and Number 10f. Zip Code must be r 10g. Citizen of What Country Funeral items 2 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ö þ 1 Never Married 2 1 Yes 2 If Yes, Give Year or Dates Married Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 Divorced Completed BACK the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. lementary/Seconday (0-12) College (1-4 or 5+) CHMERCIAL t. Page 1 and 2 should be filed with trment of Health and Mental Hygies rtant: If item 27 is marked other 1 njury or other traumatic event, th JEADE PHOLOTERY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LOISE 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town KEET DUGHTER IKIA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If if any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) MAY 31,2014 DATESVILLE . Signature of Funeral Service Licensee TUNBRAL SERVICES, INC. WRIGHT 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ SEPTIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner **MEDIASTINITIS** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed CORONARY ARTERY BYPASS GRAFTING that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Month 2 🗆 No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END STAGE RENAL DISEASE 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETES MELLITUS Director: After this certificate has in by the funeral director, page 2.3 autopsy performed? Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2X No Other: မြ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS TAT-TEE KHOO, M.D.OSLER DRIVE, TOWSON, MARYLAND 21204

DHMH 17 Rev 7/2009

State Registrar 32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:30 PM rone Medical Name (if not institution, give street and number) Examiner 4b. City, Jown, or Location of Death 4c. County of Death ursing a If Unde Date of Birth **Funeral** Months Days Hours Min. Director 28a-f show 10b. County 10a. State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No 10e. Street and Number ò 10g. Citizen of What Country Funeral 23a items ; 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 X Never Married 2 Married and Mental Hygiene. is marked other than "natural", or 9 2 X No Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) conday (0-12) Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle 0 19b. Mailing Address (Street and Number or Rural Route Number, Department of Health a Important: If item 27 is any injury or other trains 20 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Marial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens uneral Nationa FIMORE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Day Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably W Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? After this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital 8 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 Yes 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge de ath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yea 010 ss of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) gistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month Borsuk Patricia 24. 2010 12:35P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Linthicum Anne Arundel 105 Patricia Avenue Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Days March Day, Year 923 Count Minnesota **Director** 554-36-3301 87 Yrs Usual Residence of Decedent 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes No MD Anne Arundel Linthicum P 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral filed within 72 hours after death with 105 Patricia Avenue 21090 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces?
1 X Yes 2 ☐ No Black, White, etc. "natural", or ò 1 Never Married 2 Married 1 LALYes : 1 ☐ Yes 2 X No Specify: Specify: White Completed 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse **Healthcare** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William 0. Goodman Lela F.V. Madland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Alexis Drive Glen Burnie, MD 21061 Ms. Susan Borsuk / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery: 06-01-2010 Crownsville, MD MD 22. Name and Address of Facility1 2nd Avenue SW ature of Funeral Service Licensee Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ CORONARY ARTERY DISEASE 3YRS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) ned by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | d be det 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CVA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has page 2 s autopsy performed? Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director, but the funeral director, it is a second to the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 2 Nio Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 25th Tuerslin D0054739 MID MAY 811 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 7845 OAKWOOD Rd Suite 204, Glen Burnie MD DR. DONNA EVERSLEY

Registrar

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per Fh g904 6/3/10 TT

State of Maryland / Department of Health and Mental Hygiene

Amend Item 26 per dr., g903, 05/2/7/2010dnb

Certificate of Death For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Eleanor Butler Hazel 2010 May 19 РМ 1:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 302 E. Joppa Road Baltimore Parties Towson Social Security Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days 1 🗆 M 2 🗓 F Aug 19, Year 917 219-03-37973790 92 Maryland Director Usual Residence of Decedent 28a-f shov 10a. State filed within 72 hours after death with the Maryland al Hygiene. Director 10b County 10c. City, Town or Location Medical Examiner must be notified at 10d. Inside City Limits MD Baltimore Towson 1 Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 302 E. Joppa Rd., #911 21286 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: "natural", 3 X Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cleveland Naylor Estelle Grover Cora Llovd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Butler Prim-daughter 10 Schooner Ct., Nogales, Arizona 85621 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Dulaney Valley 4 Donation 5 Other (Specify) 5/25/10 Timonium, MD 21. Signature of Funeral Service Licensee William Dau G. 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Towson, MD 21204 Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ TYPUTOUSET disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** edumia Sequentially list conditions, Examine cause (Disease or linjury (UF as a sum the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 pronths? 23d. Date of delivery in the past 12 month Month Day Year the 1 ☐ Yes ∠-9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by certificate has been sign rector, page 2 should be 2 No 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed. ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital: Other: မ 1 Inpatient 2 R/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify 27. Man er of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Sigr 29d. Date signed (Month, Day, Year) llasy (org QC. majorial 0.0 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 mil nonles Friedlander スノスじこ 31. Date filed (Month, Day, Year) Registrar's Signature State 27 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Alexander Bostick Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death maryland Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 242 16 1 ₹M 2 □ F 104 Months Days Hours 4352 S.Carolina Director 1905 <u>Aug.</u> 6, Usual Residence of Decedent ural", or items 23a or 28a-f show | Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1503 N. Eden Street 21213 USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 √2 Widowed 4 □ Divorced Completed Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life DO NOT use retired)
Master
Meat Preparer Elementary/Seconday (0-12) College (1-4 or 5+) Goetzes" leat Co. 4th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Bostick Tommie Peterkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $7200~{\tt Beech~Ave.~Balto,Md.~21206}$ Hilton Bostick (son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Loudon Park Cem. May 28,2010 Balto, Md. 1 Burial 2 Cremation 3 Removal from St Donation 5 Other (Specify) ature of Funeral Service License Calvin B. Scruggs Funeral Home Preston St Balto, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death -Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine e been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? this certificate 2 No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONTINT AN Valt Ma

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amedn 29d, per MD 8903 5/27/10 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Virginia Lee Bond 91:30 PM MAY Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CENTER SAINT JOSEPH MEDICAL TOWSON BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours Min. Mal Pont 3 Pay, 1 934 76 Ma**ryTa**nd **Director** 214-30-6162 Usual Residence of Decedent 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md. Baltimore Timonium 1 ☐ Yes 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA Lough Mask Court Unit 102 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Capital Portfolio should be filed within 7 h and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Secretary Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Callahan Joseph Evelyn Virginia Peters permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Bond / Son 12 Nittnay Court New Freedom, Pa. 17349 20a. Method of Disposition
1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Hilltop Service Corp 5/26/10 4 Donation 5 Other (Specify) Towson, Maryland 21. Signatur 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause experience. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ RUPTURED ABDOMINAL ADRTIC ANEURYSM disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury that initiated events Due to (or as a consequence of) physician and the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Month Day Year ed by the a 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by as been sig 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No 2 No 1 Tes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ ER/Outpatient 3 DOA After this 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 5 Pending To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completed filled in by the fur 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 1 Certifying an: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical E On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying burse only one) Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi-29c, License number 29d. Date signed (Month, Day, Year) D 60005 May 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BENJAMIN 7601 OSLER DRIVE VANLANDINGHAM TOWSON m.D MARYLAND 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician Month DRK BROOKS 4:05 PM 0105 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL BALTIMORE N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 □ F Months Days Hours Min Director 214-76-6745 Jan 11, 1959 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Wedterl Exan, it wit to notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 316 Snowhill Lane 21225 Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☐No <u>გ</u> Specify. Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, Item Mark Injury or other traumatic event, Item Mark Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Auto Mechanic 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Clark A. Brooks Sr. Marguerite Brooks ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite Brooks 316 Snowhill Lane Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐xCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/22/10 Catonsville, Maryland Metro Crematory, Inc. 21. Signature of Funeral Service Lice 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smediate Cause (Figure 1). Approximate Interval Between Onset and Death Immediate Cause (Final SASTRO INTESTINAL **Physician** BLEEDING disease or condition resulting in death) //Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CEREBR EDEMA and Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s 24a. Was an autopsy performed 2 No 1 □ Yes Be 25. Was case referred to medical director 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. P.0. Records, Division of Vital

the Hospital or Attending Physician: The law requires that the death certificate be executed has certificate this After within 24 hours after death.

To the Funeral Director: completely

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

State

Medical

29a. Certifier

(Check only one)

ERNAUDEZ

29b. Signature and title of certifier

29c. License number RES-001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERWANDEZ 3001 SOUTH HANGUER ST, BALTIMORE, MARYLAND

31. Date filed (Month, Day, Year)

32. Poistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Severn 522 Pasture Brook Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Days Mar 4. 1942 New York 1 M 2 F Director 068-32-7730 68 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director X 1 ☐ Yes 2 ☐ No Severn Anne Arundel Maryland ö 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 21144 U.S.A 522 Pasture Brook Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. and Mental Hygiene. is marked other than "natural", or i by 1 Never Married 2 X Married 1 Yes : 72 hours after 2 🗶 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Specify: Completed Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) North Arundel Hospital Elementary/Seconday (0-12) College (1-4 or 5+) Therapist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl Robinson Joseph Robinson 1 and 2 should but the Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 522 Pasture Brook Road Severn, Maryland 21144 William Brown Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If iter 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Crownsville, Md 05/24/10 Crownsville Veterans Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Futaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that cauded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Breast disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 1 Yes 2 Unknown ed by the detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv After this certificate Yes Hospital or Attending Physician: the Funeral Director: After this certific npleted filled in by the funeral director, 25. Was case referred to medica Division of Vital Be 26. Place of Death (Check only one) 1 Yes Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10 V

Registrar

31. Date filed (Month, Day

7

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· Sec	/Medi Examir		4a. Facility Name (If not institution, give	re street and number	1 Ton	4b.	City, Town, o	or Location of Dea	ath May	4c	County of Dea		IVI
and the same	LXaiiiii	101	Northwest	Hospita	1	Ro	anda	llstow	~ MD)	Balt	more	
	Funeral Director	Г	5. Social Security Number 6. S	Gex 7. Ag		ast birthday) If U Yrs. Mor	nder 1 Year nths Days	If Under 24 Hr Hours Mir		irth Day, Year)	9. Bir	thplace (State or Fountry)	reign
	D		Usual Residence of Decedent		68_				Jan 2	2, 1942	2	Vew York	
	larylar show	ō	10a. State 10b. County Florida Orange	2		, Town or Location Orlando		economic NAME :				10d. Inside City Lin 1 Y Yes 2 □	
	the M	Director	Maryland Dalt 10e. Street and Number	more-		101	. Zip Code	ingo Millo		10g. Ci	tizen of What Co	î	
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ite Madical Extended the Indited at	al D	1612 Malon Bay	Dr.			32828	-21117			U.S.		
	er dea items	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		i. 13. Was D	ecedent of I specify Cub	Hispanic Origin? (an, Mexican, Pue	(Specify Yes or Norto Rican, etc.)	0-	14. Race - Ame Black, Whit		
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121	within iene. than "	ldmo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. DO NO	OT use retire	d)	orning .		Chu	rch	
	filed withi I Hygiene. other thar	Be Co	17. Father's Name (First, Middle, Last,)			IVIL	Isician 18. Mother's Na	ame (First, Middle	e, Maiden	Surname)		
ylar	2 should be fi and Mental H is marked ot aumatic ever	To B	George	Carter					All	berta (Cofria		
Maryland	l 2 sho h and r is ma trauma		19a. Informant's Name/Relationship (19b. Mailing Add 1612	ress (Street Malon	and Number or F Bay Dr. Prive Owings	Rural Route Num.	ber, City o	or Town, State, .	Zip Code)	
	ges 1 and 2 t of Health If item 27 i or other tra		Denise Carter Lisa 20a. Method of Disposition	Y. Cart	20b. Pla	ace of Disposition	(Name of	1	Mills, Maryl Date	7	ocation - City or		
mo			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cei	metery, crematory	or other pla		05/28/10		Baltimor		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer			Western S 22. Nam		ess of Facility	03/20/10	1	Datanioi	C, WIG.	
	20 E 29		23a. Part 1. Enter the disease, or com	. Cite			Estep B	rothers Fund	eral Service,	P. A. 12121	7		
B			shock, or heart failure. List only Immediate Cause (Final	plications thaticaused one cause on each li	the death.	Do not enter the	mode of yii	ng, such as car a	ac or respiratory	arrest,		Approximate Interval Between Onset and Death	
1	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a conseque	ence of):							-
1	Examiner		Sequentially list conditions	b	ensi								
	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	Due to (or as	a onseque	ence of):							
Ć,	be executed ician and ourial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):					:		-
3760		1-11		d									
x 687	ertifica ding ph	Med	IF FEMALE:	00 1/						- 1			
Вох	death certificate e attending phys d for use as the	Physician/Medica	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal o	death 3 Ecto	oic pregnand r (specify) _	:у		301	23d. Date of de Month	livery Day Year	
P.0.	t the d by the ached	hysi	1 □Yes 2 □No 9 □ Unknown	9 Unknown	it time of de	an 3 done	(specify) _						
S, I	law requires that the de as been signed by the a 2 should be detached	by P	Part II. Other significant conditions of	ontributing to death b	ut not result	ing in the underlyi	ng cause giv	en in Part I.	23e. Did	tobacco (use contribute to	the cause of death	?
ord	v require been si should b								. 10	Yes 2	□ No 3 □ Pi	robably 4X Unkno	own
Rec	The law ate has b page 2 s	Completed							24a. Was	psy	prior to	topsy findings availa completion of cause	
tal	an: TI Tifficate tor, pa	Be Co	25. Was case referred to medical			-		26 Place of De	1 □ Yes	ormed? 2 No	1 □ Yes	2 □ No	
of Vital Records,	ding Physiclan: The I h. After this certificate ha funeral director, page		examiner? 1 ∐ Yes 2 X No	Hospital: 1 ☐ Inpatie	ent 2. E	R/Outpatient 3	DOA Oth	or·	Home 5 ☐ Res		6 ☐ Other (Spe	cify)	
o u	ling P	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 2 y, Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe	how injur	y occurred		
Division	Attend death ctor; y the l	ficat	2 Accident investigation 3 Suicide 6 Could not be		urv - At hom	M ne, farm, street, fac		Yes 2 □ No	28f Location	(Street ar	nd Number or Ri	ıral Route Number,	
Θ	al or / s after al Dire ed in b	Certification: To	4 Homicide determined	building, etc	c. (Specify)	it, iam, on ooi, iac	,, omo		City or To	wn, State	e)	mai Fronte Humbor,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (29a. Certifier Check only One) Certifying Ph	ysician: To the best	f examination	ledge, death occur on and/or investiga	rred at the ti	me, date and place opinion, death occ	ce, and due to the curred at the time	e cause(s , date and	and manner a d place, and due	s stated. to the cause(s)	
/	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner sta	ateu.		29c. Licens	e number		29d. Da	te signed (Mont	h, Day, Year)	
			Nan for	t- wD			Do	06879	95	٢	1au)	1. 2010)
	VP		30. Name and address of person who	completed cause of d	eath (Item 2		71	1001	10	n	111	1	
	V V	•	Currette Darr 31. Date filed (Month, Day, Year)	Laton,	MD x's Signatu	5401	010	d Cont	t Kood	, Kc	mall	stown, M	
	Sta Registr	ie	MAY 272	2-010.0	4	1. back	25						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month Physician/ $20^{
m Year}_{10}$ 25 ΡМ John William Berry May 6:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center for Hospice Care Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 8 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Country) Illinois 1 🕅 M 2 □ F Months Days Hours Min. Sept. 928 Director 348-22-5234 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If fine 72 is marked other than "natural" Activation of other free any injury or other free. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 V Yes 2 ☐ No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21229 USA 509 Nottingham Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. rmed Forces?

X Yes 2 \(\sum \) No à 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: white 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Wholesale Food Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Service Delivery Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Lillian Dietz Thomas Edison Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Nottingham Road: Baltimore. MD 21229 Thomas Berry brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 5/29/2010 Mt. Vernon, IL Oakwood Cemetery 1050 York Road 21. Signature of Fun 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a chiline. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DILL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner months tumor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or impury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 ☐ No 3 ☐ Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I Yes 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 Tyes 2 X/No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 📂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DXI - Currles it Tawson m) on who completed cause of death (Item 23a) (Type, Print) 30 Name and address of pers NIES MO 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 58 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death olumbic umbia Dar 01 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F (Month, Day, Year) Months Hours Min. **Director** 217-40-Yrs 66 Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 🗆 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces?, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 14. Race - American Indian Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 ☐ Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Employment Elementary/Seconday (0-12) College (1-4 or 5+) Agenc other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James umie altimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date injury or 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. I Signatur of Funeral Service Licensee 23a. Pari 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Ca e (Final disease or andition Physician, Medical resulting in death) Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit am and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) ____ for Day Pregnant at time of death page 2 should be detached 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Records, 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 I 4 Vursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes Investigation 2 🗌 No 6
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 1. Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioners. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner accuracy. (Check only one 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) -2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 23aPtII, 25 per me, 2903, 05/2/2010dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** SHIRLEY ELIZABETH CALVERT 24, 2010 MAY 5:30 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5918 THE ALAMEDA BALTIMORE CITY N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 10/13/1929 Birthplace (State or Foreign Country)

MARYLAND 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Funeral 1 ☐ M 2 🛛 F Yrs. 220-24-7492 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ir than "natural", or items 23a or 28a-f shov 1 Yes 2 No Director MD N/A BALTIMORE CITY 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5918 THE ALAMEDA 21239 USA death v Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item eny injury or other traumatic event, the Mental once. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 DXNo Specify: Specify: 3X Widowed 4 □ Divorced WHITE 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GROCERY STORE 9TH GRADE CASHIER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY ELLEN EVANS ပ STANELY HELM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LEWIS TAYLOR/SON 8913 DEER LANE STEWARTSTOWN. PA 17363 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE CEMETERY 5/27/2010 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Rata Ta 8521 LOCH RAVEN BLVD. TOWSON. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Malti **Physician** disease or condition resulting in death) organ /Medical 21 days Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed Sacral signed by the attending physician and it be detached for use as the burial-trans Due to (or as a consequence of): Box 68760, Completed by Physician/Medical CERTIFICAT IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ 6 P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Hypertension, 1 🗌 Yes 2X No 3 Probably 4 Unknown peen : Left Femur Fracture 4a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? 1 ☐ Yes 2 🖾 No this certificate (Pathological) Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner: 1**X**Yes 2√No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 XNatural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DB665032 5/25/2010 Mojno

DHMH 17 Rev 1/2001

State

Registrar

447 York Rd. Lutherville,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sanchez

Karla

MAY 27 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 19, 2010 12:15 p Maggie H. Carter /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Manor Care-Roland Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 F Hours Country) No. Carolina Yrs Feb 26, 1930 Director 80 218-26-9057 Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at once. 10a. State 10h County 10c. City, Town or Location 1 Yes 2 □ No Director **Baltimore** Maryland N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21206 5544 Whitby Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Black \$ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) **GBMC** Hospital Elementary/Secondary (0-12) College (1-4or 5+) Dental Helper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Not Known Not Known ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5544 Whitby Road Baltimore, Maryland 21206 Heidi Bovd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/25/10 Baltimore, Md Woodlawn Cemetery & Chapel 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. MYPERTENSIVE **Physician** CARDIOVACCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): the attending physician Physician/Medical SS IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 ☐ Other (specify) is been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à MELLITUS DIABETES 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 2 2 □ No 1 □ Yes 2**X**No 1 ☐Yes Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760,

within 24 hours after death To the Funeral Director: filled in by Hospital completely

(Check only one

29b. Signature and title of certifier

6 State

USINESS CENT 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0059107

29d. Date signed (Month. Day, Year)

DRINE REISTERSTOWN MD 21136

		1	_ State	of Maryland /	-	rtment of H tificate of L			grene leg. No.)	1 - 1 - 7 0
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dear	th CUT	3. Time of Death
	Physicia		August	E. Cut	fley	1		May 22	, 2010 Year	10:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and	number)			Location of Death		4c. County of Dea	
			Renaissance Gardens				sville		Baltimo	
Т	Funeral		5. Social Security Number 6. Sex 1 対 M 2 □ I	7. Age (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 24	Year) 9. Bi	rthplace (State or Foreign Country) Maryland
	Director		220-07-8245 Usual Residence of Decedent	88	113.			June 24	, 1921	rialyland
	land ow		10a. State 10b. County	10c. City, To	own or Lo	cation				10d. Inside City Limits
	Mary a-f sh	햐	MD Baltimore	Cat	onsv	il le				1 □Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What C	ountry?
	th wil	la [719 Maiden Choice Lane	HR545		21228				
	tems	Funeral	Armed	ecedent Ever in U.S. Forces?	13. \	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
36	s afte	by F	If Yes,	s 2∐No Give WWII or Dates:		1 □Yes 2x No	Specify:		Specify:	White
ş	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, its Medical Evertime intelliging at		15. Decedent's Education	10	6a. Dece	dent's Usual Occup	ation	[16b. Kind of Busines	s/Industry
215	hin 72 e. an "na Medi	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	life. I	kind of work done of DO NOT use retired	l)		D. 41 14	lawatewatin
2	ygien ygien er tha	Son.	7		Stea	mfitter				Construction
		Be	17. Father's Name (First, Middle, Last)						Maiden Surname) nrenberg	
<u> </u>	should be filed and Mental Hygi s marked other umatic event, II	은	Raymond Olester Cuffle		Ob Mailie	Addraga (Street			er, City or Town, State	Zin Code)
Maryland 21215-003	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationship (Type. Print) Elsie Mildred Cuffley	Sister					timore, MD	
<u>ق</u>	Heal Heal tem 2		20a. Method of Disposition			sition (Name of matory or other place		Date	20c. Location - City of	
ē	Pages ent of nt; If i	ĺ	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State Loud	lon P	ark Cemet	tery 5/27	/2010	Baltimore,	
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic evonce.	1	21. Signature of Funeral Service Licensee	moisso	22	2. Name and Addre	ss of Facility Ste	rling A	shton Schw le, Inc.	ab Witzke
ñ	B I I G		MICK TEUM	100	1	.630 Edmoi	ndson Ave	nue; Ca	tonsville,	MD 21220
			23a. Part 1. Enter the isease, or complications the shock, or heart failure. List only one cause of	at caused the death. I	o not en	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
1 100	Physician		Immediate Cause (Final disease or condition	monary to 61	055	with (or Palm	male.		Gefore 2006
j.	/Medical Examiner		resulting in death)	to (or as a consequen	ce of):					\mathcal{C}
		-	Sequentially list conditions, if any, leading to immediate Due	to (or as a consequen	ce of):					-
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	e exec an an irial-tr	Exa	resulting in death) Last Due	to (or as a consequen	ce of):					
8760,	icate be executed physician and s the burial-transit	dical	d			,				
Θ	ertific ding p		IF FEMALE: 23c If was	outcome of pregnancy	u .				23d. Date of	delivery
Вох	atten for us	ian	in the past 12 months?	ive birth 2 Fetal de	eath 3[☐ Ectopic pregnand ☐ Other (specify) _	;y		Month	Day Year
o	Physician: The law requires that the death certificate that been signed by the attending this certificate has been signed by the attending rail director, page 2 should be detached for use as	by Physician/M		Jnknown					i	
S, P	s that ned b	y P	Part II. Other significant conditions contributing	to death but not resultin	ng in the u	inderlying cause giv	en in Part I.	23e. Did to		to the cause of death?
ğ	quire: en sig uld br	ed b	_CHF					10`	Yes 2 □No 3 □	Probably 4 Unknown
900	e law requir has been s je 2 should l	Completed	Chronic renal fois	Vue				24a. Was autor	psy prior	autopsy findings available to completion of cause of
Ě	The arte har page	ĕ	/					perfo 1 □ Yes	ormed? death 2⊿No 1□Y	es 2 No
/ita	clan: ertific ector,	Be	25. Was case referred to medical examiner?			104	26. Place of Dea			
_	Physi this o			I ☐ Inpatient 2 ☐ ER	NOutpatie Bb. Time of	ent 3 LI DOA			dence 6 Other (S	pecify)
Division of Vital Record	Jing Fune	tion	1 Natural 5 Pending (Month, Day, Year)	Injury	Wor	k?]Yes 2∐No	200. 200. 20		
isi	Attending ir death. ector: After by the fune	fica	3 Suicide 6 Could not be 28e. F	lace of Injury - At home	e, farm, st	reet, factory, office		28f. Location (Street and Number or	Rural Route Number,
5	al or safter	Certification: To	4 ☐ Homicide	uilding, etc. (Specify)				City or To	wii, Glale)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Examiner: On	the best of my knowle	edge, dea n and/or i	th occurred at the t	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	the H hin 24 the F mplete	Medical	one) and	manner stated.		29c. Licen			29d. Date signed (M	
	o viti	_	29b. Signature and title of certifier	e ll			39297		5/2	4/10
			30. Name and address of person who completed	cause of death (Itam 2	3a) (Tune		21011		-/-	,
1			James Evans, M.D., 7	09 Maiden	Choi	ce Lane,	Catonsvil	lle, MD	21228	
	St	ate	31. Date filed (Month, Day, Year) MAY 2 7 201	32. Registrars Signatur	e A	6.0	/			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alatha Davis Month 2010 12:20AM MAY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 7. Age (In yrs. last birthday) If Unde If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country)
Carolina 1 □ M 2X7 F Months Hours Min (Month Davs 64 Director 247-84-3107 Usual Residence of Decedent 23a or 28a-f show 10a, State 10b. County 10c. City. Town or Location Examiner must be notified at 10d. Inside City Limits Director MD N/ABaltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4606 Moravia Run Way 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 0 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3XWidowed 4 ☐ Divorced Black event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 8th Grade Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Curtis Lee Hickman Inez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 4606 Moravia Run Way Baltimore, MD 21206 Health tem 27 i Irenerenette Ellis/Daughter Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 5/29/10 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Pk. Parkville, MD 22. Name and Address of Facility Chatman-Harris Funeral . Signature of Funeral Service Licenses Home 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death

On Myown Immediate Cause (Final Physician/ Medical resulting in death) Examiner unhnow Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury signed by the attending physician and I be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work 1 Tes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signature a ditle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h, Day, Year) 32. F 31. Date filed (Mon

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G904, 6/9/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 049 1403 PM Month **MIC** Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns Hopking Barview Medical Center Ballimore 6. Sex Age (In yrs. last birthday) f Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Months Hours Min Director MD Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD na 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 US Α 3527 Woodstock Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Black Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry na (Give kind of work done during most of working na life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>6th grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ LuLu Lock Dewitt Leazer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1903 Kennedv Avenue Balto, MD 21218 19a. Informant's Name/Relationship (Type, Print) 1903 Kennedy Avenue Patricia Douglas-Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Memorial Pk 6-2-2010 4 Donation 5 Qther (Specify) Randallstown, March East F/H 21. Signature of Fun Service Licen 22. Name and Address of Facility MD 21202 1101 E. North Avenue Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between O set and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a cor Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 ☐ Pregnant at time of death g ☐ Unknown Month Year ate has been signed by the a page 2 should be detached f g 🗌 Unknown Part II. **Oth**er s**ignificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) ဂ္ 1 Yes 2 1 No Other: 1 Dinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 🗆 within 2 To the 1 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) venul, Bathmare, UD, 21224 4940 Baskin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Dep 25 per verb., g903	artment of Health and Mental Hygiene 05/27/2010dhb Reg. No. 2
			Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physici /Medic		William Lames Thomas	Daniels, It May 12 2010 2:47 AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
1			The Johns Hopkins Hospital	Baltimore City
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) Country)
١	Director		403-52-1998 69	June 18, 1940 Kentucky
-	W C		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation 10d. Inside City Limits
1	f sho	ō		1 ▼ Ves 2 □ No
4	28a	Director	10e. Street and Number	dre Island 10f. Zip-Code 10g. Citizen of What Country?
1	3a or		5550 Gulf Blvd., Florence 1 #306	78597 U.S.A.
d 21215-0036	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No-
9	or ite		Armed Forces? 1 □ Never Married 21☑ Married 11☑ Yes 2 □ No	f Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.
21215-0036	al", c	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	I Yes 2♥No Specify: Specify: White
2-0	natur	Completed		dent's Usual Occupation 16b. Kind of Business/Industry kind of work done during most of working
2	Med 1	np(Elementary/Secondary (0-12) College (1-4 or 5+)	DO NOT use retired) United States
2	ygien ygien er th	S	12th 5 Sold:	
Š 3	d off	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
aryla _{should}	Men	6	William J.T. Daniels, Sr.	Irene Agatha Edwards
اعلا چ	is mg		19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
				Lagoon Drive, CLarks Hill, South Carolina 29821
Baltimore,	3 S = 5		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Place of Disposition cemeterly, crei	sition (Name of Date 20c. Location - City or Town, State natory or other place)
E a	artment ortant: II			el Crematory May 21, 10 Odenton, Maryland
e	lmi orta			Name and Address of Facility Donaldson Funeral Home, P.A.
	-C-2 # 0	v=9		13 Talbott Avenue, Laurel, MD 20707
		Ш	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	Interval Between
	nysician		Immediate Cause (Find disease or condition resulting in death) a. Myo cardial	Infarction
	Medical xaminer		Due to (or s a consequence of):	
	7	ē	Sequentially list conditions, if any, leading to immunicate. Due to lor as a consequence of the control of the	
-	sit	Examiner	cause. Enter Underlying Cause (Disease or injury	
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, d	physician and s the burial-transit	edical		
cords, P.O. Box 68760, requires that the death certificate be executed			d	
X Gertifi	been signed by the attending should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery
Box	atter d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐	Ectopic pregnancy Month Day Year
S. Harrie	y the	hys	9 Unknown 9 Unknown	
ੁੱ, _ਵ	ed b	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
rds Ulres	sign Jd blu			1 Ses 2 No 3 Probably 4 Unknown
<u>o</u>	0 0	Completed		24a. Was an 24b. Were autopsy findings available
- He law	has age 2	шо		autopsy prior to completion of cause of death?
	ficate or, pa	Ф	25. Was case referred to medical	1
rsicia	after death. Director: After this certificate has in by the funeral director, page 2	P B	examiner? 1 Yes 2 X No Hospital: 1 Impatient 2 ER/Outpatien	Othor
o a	er this		27. Manner of Death 28a. Date of Injury 28b. Time o	28c. Injury at 28d. Describe how injury occurred
UIVISION or Attending	ath. :: Affe	atio	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? 1
VIS	by by	iitic	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street building, etc. (Specify)	et, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
בַּ ב	s afte	Certification:	- January out (Spoory)	
ospit	hour unere		29a. Certifier (check only (ch	occurred at the time, date and place, and due to the cause(s) and manner as stated. estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
) H	within 24 hours after To the Funeral Dir completely filled in	Medical	and manner stated.	
6	To no	2	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
1	41		Michaelia Lake	RES 000 May 12 2010
10	ן ידע		30. Name and address of person who completed cause of death (Item 23a) (Type, Mikhailia Lake	*
	Stat		MILhailia Lake 31. Date filed (Month, Day, Year) 32. Registrar's Signature	600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 24a per verb., 9904,06/04/2010dhb

Amend Item 26 per verb., 903,05/27/2010dhb

Certificate of Death

Reg. No. [] 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** May 10 2010 10:03 A^{M} Nancy Jayre Darabpour /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2 Montgomery Village Ave; Rm 627 Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 4/14/1961 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 💥 🛪 F Min 49 IN Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Mucical Expirition of the motified at MD 1 Yes 2 No Montgomery Gaithersburg Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 102 Duvall Lane # 204 20877 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ No Specify. Specify. ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 US Government 1.2 should be filed wh and Mental Hygie7 is marked other tf 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reed F. Motsinger permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Roberta Janet Myers ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6303 East Farabee Road, Salem IN 47167 Janet Motsinger / Mother 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Blue River Baptist Cemetery 5/20/10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Si reture of runeral Service LicenseeVictor P. Doda, Jr 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INTERSTITIAL **Physician** UNG /Medical Due to (or as a consequence of): REE NON Examiner THROMBOCY TOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine CYMPHADENOPATHY and burial-trar Due to (or as a consequence of): the attending physician Box 68760 AlthomeGAL Physician/Medical the use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy for Month Year in the past 12 months? 1 □Yes 2 ☑ No Dav 5 ☐ Other (specify) detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? HEPATITIC certificate 1 ☐ Yes 2 ☐ No 1 □ Yes of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient S ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hotel Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of co 2252 mo CTR. DRING 9715 MEDI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOJEPH GRBERLY wo 31. Date filed (Month, Day, Year) 32.' Registrar's Signature MAY 27 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 0413 M 290 acquel ah /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maryland 7 More If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, **Funeral** Hours Min Country Months 1 M 2 □ F Yrs Mary Director Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Example Activitied at 1 Nes 2 No Director nover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 IOWI Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Decement's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 1ante ပ 19b. Mailing Address (Street and Number or Rural Route Numbern City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) OWY Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 3 Removal from State 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Littles 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Devere disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Charnital Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transi remetu and Due to (or as a consequence of) attending physician Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∭X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0068055 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene. Abebe Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 22, William Joseph Dircks 2010 12:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death N/A 1441 Medfield Avenue Baltimore . Social Security Number 8. Date of Birth (Month, Day, March 2 If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Days 90 Hours 1**XX**M 2 □ F Country) 214-07-3404 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 1441 Medfield Avenue Funeral U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ▼ Section 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 XX arried Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 XXo Specify: White "natural" 3 Divorced 4 Divorced Specify: Completed Year or Dates. WWII the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Local 101 Carpenter 4th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul John Dircks Barbara Ellen Barthow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Dircks 1441 Medfield Avenue Balto, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial 20c. Location - City or Town, State Date XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/27/10 Cumberland, MD Signature of Funeral Pervice Liners 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral
3631 Falls Road Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final rneumonia Physician/ mongz Medical resulting in death) Examiner whenche ulmonun SCASR MONT Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 004337 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARTIMENE MD ZIZUS MITH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26 per MD G903 5/27/10 TT
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5:45 A M Physician/ George Robert Davidson 2010 May Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson <u> Joseph Medical Center</u> If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Age (In yrs. last birthday) Funeral Hours Davs 8/18h/1926 1 **X**M 2 □ F 83 214-22-0051 Yrs Maryland Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 XNo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?, Funeral 21204 8105 Rider Ave. U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces' Black, White, etc. Completed by 1 Never Married 2 X Married 1x x Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Mechanical Engineering Consultant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Ellsworth Davidson ပ Emily Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8105 Rider Ave. Baltimore, Maryland 21204 Norma Davidson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp; 5/24/2010 | Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fune al Service 1050 York Road Towson, Maryland 21204 Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. yeath Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy performe prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 No 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 XDOA 4 Nursing Home 5 Pheside ၉ 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner_of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 003012 1741 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 2010 02:40P M JANICE DANSICKER Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE CARE TOWSON BALTIMORE Birthplace (State or Foreign Country)
 Mn 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. 1 M 2 X F 64 Yrs. 0370271946 MD **Director** 212-50-0408 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ıral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Tes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19 SADDLE COURT 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed WHITE traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than " Elementary/Seconday (0-12) College (1-4 or 5+) SOCIAL WORKER MEDICAL is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fill Health and Mental ၉ ALBERT FRIEDMAN SARA BAYLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 SADDLE COURT, PIKESVILLE, MD 21208 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr MARTIN DANSICKER / HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) OHEB SHALOM MEM. PARK 05/26/2010 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS.. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priset and Death Physician/ 4 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Pregnant at time of death ned by the at e detached fo 9 Unknown Hospital or Attending Physician: The law requires that the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ been signe should be c Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy this certificate Be 25. Was case referred to medical **Division of Vital** completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No Hospital: 1 Yes PILE ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred After iniury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print)
W 6701 N. CHARLES ST. BALTIMORE, MI who completed 30. Name and address of person MEUSSA J. WOLF 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 19a, per Fh G904 6/1/10 TT
State of Maryland / Department of Health and Mental Hygiene
1- State Amend Items 23aPtII,25 per me g903,05/27/2010dhb
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Reg. No. 2 | | | Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner NA Social Security Number 53 Yrs. If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 X M 2 - F 0 2 on 1 Pay 5 7 Director 216-68-585 MD Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County e filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1XXYes 2 No MD NA Baltimore 10e, Street and Number #1103 10f. Zip Code 10g. Citizen of What Country? Funeral 1104 Druid Hill Avenue Apt. 21201 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 14. Race - American Indian, Black, White, etcAfrican 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: American 3 Widowed 4X Divorced Completed Year or Dates permit. Page 1 and 2 should e filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is mar ed other than "natur any injury or other traumatir event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>12th Grade</u> NA Truck Driver Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Ebb Jewe1 Robinson 19a. Informant's Name/Relationship (Type, Print)
Keith Epp, Sr. - E 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr.-Brother 708 Cliefedge Road Pikesville, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 2Ωa Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial ②XCXCremation 3 ☐ Removal from State 05-17-10 Catonsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Wylie Funeral Home P.A 22. Name and Address of Facility 638 Gilmor Ν. Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ptiysician, disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Al led by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by due to Epidural Abscess Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy perform 2 No Yes 2 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Our titying Number Fractionar: To the basis of my knowledge dueth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WW. 301 57 MIN 31. Date filed (Month, Day, Year) Registrar's Signaty State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year 6:55 Delores Evans PM MAY 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death University Maryland N/A Baltimore Medical 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 1 M 2 F Days 55 Months Hours Min. (Month, Day, Year) 212-60-4004 Director 1955Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore N/AMaryland 1X Yes 2 No 10f. Zip Code 21 21 7 10e. Street and Number 10g. Citizen of What Country? Funeral 1308 W. Layfayette Avenue USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Black If Yes Give 1 ☐ Yes 2x☐ No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Harris Donald H. Ames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 1308 W. Layfayette Ayania Baltimore, Maryland Donald Evans/ Husband t: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Baltimore, Maryland Greenmount Cemetery 21. Signature A Funeral Service Licers 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fajure. List only one cause on each line. 3a Part 1 Enter the dis Approximate Interval Between Immediate Cause (Final Onset and Death Physician Naso Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: ျပ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 Pending (Month, Day, Year) 1 X Natural work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: Af Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after

To the Funeral Direct

completed filled in b Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 19650 May 19,2010 se of death (Item 23a) (Type, Print) 30. Name and address of person who completed car South Greene 22 Baltimore no 21201 31. Date filed (Month Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Jimmy DU E 10-03867 UNK UNK	:In	m, Jr.
Physici Medical Exami		1- For State Registrar 1. Decedent
j		4a. Facility Unive
Funeral Director		5. Social Se
11215-0036 Ide filed within 72 hours after death with the Maryland denal Hygiene, and arked other than "natural", or items 23a or 28a-f show any event, the Medical Examiner must be notified at once.	o Be Completed by Funeral Director	Usual Residence MD • 10a. State MD • 10e. Street 10e. Street 11. Marital 12. Neve 15. Deced Elementa 17. Father's JTM 19a. Information 19a. In

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2010 16589

		1- For State Certific Registrar	ficate of Death		Reg.	2010 No.	0305
Physici	an/	Decedent's Name (First, Middle,Last)			Date of Death Month	Day Year	3. Time of Death
edical Exami	ner	JIMMI DEE EFION 1K.			May 20, 201	l 0	1506 hrs
		Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Baltimore	Location of Death	1	4c. County of Death N/A	
				or I following Odling	Date of Birth		onlane (State or
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	Months Days			(MM/DD/YYYY) 9. Birtl Foreign	1
Director		220-31-9223 1XM 2F 1	9 Yrs.		4-27-1	991 000	intry)MARYLAND
è		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location				10d. Inside City Limits
. A .							1 Yes 2 No
Maryland 28a-f show any <u>d at once.</u>	ţċ	MD N/A BAL	TIMORE 10f. Zip Code	 	100	. Citizen of What Coun	-11
e Ma or 28 fied a	Director			_	1.09		,.
eath with the Maryland items 23a or 28a-f sho ust be notified at once.		2954 CLIFTON AVE. 11. Marital Status 12. Was Decedent Ever in U.S.	2121 (pecify Yes or No-	USA 14. Race - Americ	ean Indian Black
r death wi or items must be	Funeral	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban			White, etc.	arringari, black,
her de		1 Yes 2X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No	specify:		Specify: BLA	CK
ours at	d b	or Dates: 15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupat	tion (Give kind of		6b. Kind of Business/Ir	
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5-0036 led within 7 Hygiene. lother than	ш	-100-	LABORER			CONSTRUC	TION
15-0 iled v Hygi Hothy		17. Father's Name (First, Middle, Last)		18.Mother's Name	e (First, Middle, Ma	iden Surname)	
121 d be fi lental	Be	JIMMY DEE ELTON SR. 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Stree	DEBRA	D. SUMME	ERVILLE	
D 21 should and Me 7 is ma	٦	_					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fahr injury or other traumatic event, the Medical Examiner must be notified at once	- 1	DEBRA SUMMERVILLE (MOTHER) 20a. Method of Disposition 20b. Pla	2954 CLIFTON ce of Disposition (Name of cer		ALTIMORE, Date	MARY LAND 20c. Location - City or	Z1Z16 Town, State
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra			matory or other place)			•	. ,
ti Par		4 Donaton 5 Other Specify: MT.	ZION CEMETERY	5-2	<u> 29–2010 </u>	BALTIMORE,	MARYLAND
Bal Bal Depa Impo injur		21. Signature of Funeral Service Learning ONASHAN D. HI					
Physician	-	23 Part I. Enter the disease, or complications that caused the death. Do	not enter the mode of dying,	such as cardiac of	ST BALT or respiratory arrest	TMORE MAR	YLAND 21217 Approximate Interval
/Medical		fallure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot wound of chest					Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Gunsnot wound of chest Due to (or as a consequence of):					
		Sequentially list conditions, b					
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause					
	am	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleanh. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		d					
be exe	Medical	UNPENDED AMENDED					
760, ficate be g physici the buri		IF FEMALE: 23b. Was decedent pregnant in the				23d. Date of delivery	
certif	cia	past 12 months?	2	Ectopic pregna	ancy	Month D	ay Year
Box 68 death certif he attending of for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown	Ulifer (Opecity)			ļ	
D.O. Box 68 that the death certifined by the attending detached for use as		Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause o	given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
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Vital Rec ysician: The his certificate director, page	O B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 Y EF		Othor:	ng Home 5 R	esidence 6 Other	
n of Vital Records, iing Physician: The law require. After this certificate has been s funeral director, page 2 should t	-	27. Manner of Death 28a. Date of Injury 28	Bb. Time of Injury 28c. Injur	ry at Work?	28d. Describe ho	w injury occurred	
Division tal or Attendir rs after death. al Director: A led in by the fu	ertification:	1 Natural 5 Pending May 20, 2010 1	422 hrs 1	Yes 2 V No	Subject shot		
ivision or Attencather death Director:	iţi		e, farm, street, factory, office b	ouilding, etc.	28f. Location (Str or Town, Sta	eet and Number or Ru	al Route Number, City
Dital ours a cral I	Cert	4 V Homicide determined (Specify) Field			3000 Block of V	Vest North Avenue,	Baltimore, MD
Division To the Hospital or Attend within 24 hours after death To the Funcral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge,					
To th withir comp	Medical	one) 2 Medical Examiner: On the basis of examination and/ and manner stated.					
	Σ	29b. Signature and title of certifier	29c. Licens			29d. Date signed (Mon	ntn, Day, Year)
		Callville	O.C.I	IVI. ⊏.		May 21, 2010	
BV		30. Name and address of person who completed cause of death (It + 23 Zabjullah Ali, M.D. Assistant Medical Examiner	^{ga)} 111 Penn Street, Balt	timore MD 21	201		
	tate	20 0 0 0	4 4 .				
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ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 la 8:46 Medical acility Name (if not institution, Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPICE Haltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗙 F Months 92 Yrs. Director or 28a-f shov 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at 10b. County 10d. Inside City Limits Director Baltimore 1 X Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1304 Avenue items 23a Winston 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No "natural", 3 Widowed 4 ☐ Divorced Completed Specify: Klack injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Publications Jupewisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental t မ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or any Wiggins be Blanche ler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. Shaw Chinquapin Baltimore, Muryland 2123 Daughter 6115 cqueline Baltimore, 20a. Method of Disposition

1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 0 MO155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Priysician/ emplications disease or condition weeks Medical resulting in death) Due to (or a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Unknown signed by the g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by perative smoke, 1 ☐ Yes 2 Xho 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Tyes ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) exeminer? 2 🗌 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICO 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 830 5 Pending 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 🗌 Yes 2 Accident Investigation 6 Could not be UNWITHERED Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined nome 304 Winston Ave, BALTHING MI Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🖂 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier es of person who completed cause of death (Item 23a) (Type, Print) N. Charles 10 31. Date filed (Md Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Û LCIA Octo 2010 /Medical acility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner columbia A DU 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Texas Social Security Number 6/ Sex rs. last birthday) **Funeral** Months Days Min 1 □ M 2 🖾 F Hours Yrs. 498-60-8161 Director May 12, Usual Residence of Decedent 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural" or items 23a or 28a-f shot traumatic event, the World Experience must be notified at 1 ∏Yes 2 XINo Director Maryland Howard Columbia 5 1 the 10e. Street and Number 10g. Citizen of What Country? death with 7203 Harbor Lane 21045 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or ite 1 Never Married 2 N Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: White ≥ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired Conputer Programmer. Unitarian Universalist Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked: any Injury or other traumatic evance. ည Norman Neel Proctor Katherine Eugenia Milton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter L. Fort/ Husband 7203 Harbor Lane, Columbia, Maryland 21045 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 26, 2010 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Metro Cremacry, Inc. 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licenses Leo 299 Frederick Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Meroscle **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the use as attending properties for use as IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. ed by the detached f 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3/DOA this Medical Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 🗆 Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) d erson who completed cause of death (Item 23a) (Type, Print) 30. Name and addr

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month OS **Physician** tunder bur 21 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Itealth Maryland and Rehalo verlea Baltimore 9. Birthplace (State or Foreign Country) North Carolina Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 □ M 2 🖫 F 215-28-3950 92 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the statement of the statement of the statement in the statement of the statement in the statement 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Nes 2 No by Funeral Director 17 more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21211 eming 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Black Specify: 3 Nidowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domes 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Remmell Ave Maella alto 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Kaltimore 5 □Other (Specify) 4 Donation Funeral Service Lice 22. Name and Address of Facility 46050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSUS disease or condition resulting in death) /Medical Due to (or as a consequence of): PNEUMATOSIS Examiner Sequentially list conditions, if any, reading to minimum cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): sate has been signed by the attending physician a page 2 should be detached for use as the burials Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 2 🖼 No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Table Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 50060560 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106, 1HILADELPHIA PANIGAT # 208 BALTIMORE, MD KAETERPA

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day;

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 3:05 Frank Faust AM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Raltimore Union Memorial Hospital 8. Date of Birth (Month, Day, Year) Mar 27, 1936 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 □xM 2 □ F Hours Country)
So. Carolina Director 248-78-2064 Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director 1 Yes 2 No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 21215 U.S.A. 2519 Quantico Avenue within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 ☐ No Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify Black "natural", Completed 3 Divorced 4 Divorced 1 and 2 should be filed within 72 hour of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Company Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lessie Johnson Elijah Faust 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2519 Quantico Avenue Baltimore, Maryland 21215 Odessa Faust Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit, Page 1
Department of
Important: If if
any injury or o ō 1 🔲 Burial 2 🗘 Cremation 3 🔲 Removal from State 05/25/10 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral S in e Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Futaw Place Baltimore, Md 2 Eutaw Place Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Week disease or condition resulting in death) Medical **Examiner** ural Hematoma Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury prostate cancer with bone metastanis or Attending Physician: The law requires that the death certificate be executed after death. ending physician and use as the burial-transit that initiated events resulting in death) Last signed by the attending physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) 1 Yes 2 Unknown should be detached 9 I Linknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No s after death.

Director; After this certificate 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier 1 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Continuing Name Practiciner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) A +24 38 94666 pour a 5,22,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Paltimore, MO 21218

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 19a per fh 9904 6-22-10 yt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month May 24, 2010 Joseph W. Ferandes 4:30 p ^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) 18,1942 Baltimore 902 S. Ponca Street If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 □ F 67 Yrs 212-40-0381 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d Inside City Limits "natural", or Items 23a or 28a-f show Baltimore Md 1 XIYes 2□No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 902 S. Ponca Street U.S.A.

14. Race - American Indian 21224 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ZYes 2 No Navy If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Vietnam Completed Medical ecedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (MOTe), Inc.

1. Pages 1 and 2 should be filed within...

4. Health and Mental Hygiene.

7. Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Revere Copper/Brass the Factory Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I-Important: If Item 27 Is marked ot any Injury or other traumatic ever Curtis Mary 2 Ferandes Α. Joseph 19a. Informant's Name/Relationship (Type. Print)
Amelia
M Formal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 S. Ponca Street Ferandes Balto. Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-2-2010 Owings Mills, Md. Veterans Cem. 4 □ Donation 5 □ Other (Specify) Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. Kin 263 S. Conkling St. Balto. Md. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fina disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Energy Grant Cause (Disease or injury Due to (or as a consequence of): Examiner physician and is the bunal-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown phone 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy perform certificate 1□ Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

death with the Maryland

hours after

within 72 l

the death certificate be executed

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

To the Hospital

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who comple

10 32. Registrar's Signature

use of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FLOWERS Year Physician/ 850 AM OHN 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown NorthWEST HOSPITAL Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🙀 M 2 🗆 F Days Months Hours (Month, Day, Year) Director 218-28-8903 Jun 13. Maryland Usual Residence of Decedent 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Randallstown Baltimore Marvland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 27 Sheraton Road U.S.A 21133 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🛣 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 ₩ Widowed 4 □ Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Merchant Seaman Seaman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jane G. Flowers John Dave Flowers Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Sheraton Road Randallstown, Maryland 21133 Kathi Pendleton 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗶 Burial 2 🗌 Cremation 3 🔲 Removal from State 05/28/10 Windsor Mill, Md. 4 Donation B Other (Specify) King Memorial Park Funeral Service Licen 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 213 Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ SEASIS disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner feeted Wound Sequentially list conditions, If any leading to immedicause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death been signed by the sahould be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 performed' 2 - No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No Certificate: To 1 Impatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural (Month, Day, Year) 5 Pending 1 Yes 2 No □ Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D65843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print CourtRoad, Randallstown, HD 21133 Marrouni 31 Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, g903,05/27/2010dhb

Certificate of Death

Reg. No. 1 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month RIL Day : Physician/ 12:15FM Year Sophie Gizinski Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Center Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** September 1 □ M 2 🗐 Months Days Hours Min, 1928 Maryland Director 215-22-0576 18, Usual Residence of Decedent items 23a or 28a-f show ler must be notified at 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Md. Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 802 Falconer Road 21085 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ , o 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 al Hygiene. d other than "natural", c event, the Medical Exan 1 Yes 2 No Specify Specify: 3 XWidowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Billing Hopkins Hospital ulth and Mental Hygie 27 is marked other r traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injuy or other traumatic even once. ည Rose Krol John Ermatowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Douglass DTR. 1400 Lake Vista Drive Joppa, Md. 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-26-2010 Balto. Md. Most Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) Schimunek Funeral Home Signature of Funeral Service Licenses 22. Name and Address of Facility teka 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final INTRACRANIAL HEMORRHAGE Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Dure to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last CERTIFICATION Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year be detached 9 Unknow þ Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 1 Tyes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practice of the local of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated. completed within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 DØØ63974 MN BUK! 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D. OSLER DRIVE TOWSON, MARYLAND 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

amend item 5 per fb g904 6-11-10 yt and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pennsulvania 125 Avenue 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign Country) If Under 24 Hrs **Funeral** Hours 1 □ M 2 🗙 F MD Director Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. Count 10d. Inside City Limits 10c. City. Town or Location 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral "natural", or items Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 21215-0036 1 ☐ Yes 2 🗙 No Specify: 3 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the NA Elementary/Seconday (0-12) College (1-4 or 5+) 2 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည 21157 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 29/2010 stminster 4 Donation 5 Other (Specify) Signatur of Theral Service Licensee Main 21157 where the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician o min disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death been signed by the s should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? 2 \square No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 ☐ Nursing Home 5 🕷 Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 X Natural 5 Pending work? 2 🗌 No within 24 hours after death. To the Funeral Director: A Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Victoria 2 Date of Death 3. Time of Death Glinowiecki Year 1745 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TALBO MEMORIAL OSPITAL AT EASTON SASTOU If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 12/23/1915 Birthplace (State or Foreign Country) Min. 22018-7711 1 □ M 2 □ ¥ Months Davs Hours 94 MD Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a State 10c. City. Town or Location MD Queen Anne's Stevensville 1X Yes 2 ☐ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 212 Queen Anne Road 21666 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🔥No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □Yes 2 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: white 3 →Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Social Security Admin 17. Father's Name (First, Middle, Last)
Michael Lorent 18. Mother's Name (First, Middle, Maiden Surname) Stella Turowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Queen Anne Rd, Stevensville, MD 21666 19a. Informant's Name/Relationship (Type. Print) Hope A. Walzak / Daughter 20b. Place of Disposition (Name of cometary, crematory of other place)
Ardent Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 5/27/2010 Hanover Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Victor P. Doda, Jr. 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 06951 Cardiac 2 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 DWo 1 Apatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician /Medical Examiner P.O. Box 68760. Records, of Vital Division

Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. 4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and burial-tran the for use as detached page 2 s funeral director. filled in by the

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Certification: To

29a Certifier

29b. Signature and title of certifier

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d other than "natural", or items 23a or 28a-f slevent, the Wedleal Examinar must be notified

death

1 and 2 should be filed within Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If Item 27 Is marked other the any Injury or other traumatic event, the any Injury or other traumatic event, the once.

Maryland 21215-0036

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and manner stated.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

† Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number DOO

Washington

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 50 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GNES ALTIMORE SPIT Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F Months Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be retified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 HNo Director MI 10g. Citizen of What Country? 10e. Street and Number 4500 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Dres 2 No If Yes, Give Year or Dates: 1951 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 2 Specify: 13/9CK 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Suname) Be 17. Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 MD21117 1500 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 4 ☐ Donation 5 ☐ Other (Specify) ,28-2010 Triangle 22. Name an Address of Facility Vaughn C. Greene Fundral Services 21. Signatur∉ of Funeral Service Randallsturn, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PTIS 400,25 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LOURS NEUMONIA Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last rsician and burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: signed by the attendin 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performer 2 No 1 □Yes 2 □No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director; After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No completely filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SLAIBI CONTE 900 CATON AVENUE BALTIMORE RICARDO AUGUSTO 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State of Maryland / Department of Health and Mental Hygiene | | | | | |

State of Maryland / Department of Health and Mental Hygiene | | | | |

Registrar | | | | | | | |

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth May 24. 2010 Ann Grogan 5:42A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7111 Rumford Drive Glen Burnie Anne Arundel 5. Social Security Number 04 234-44 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🖁 F Days Hours Min. Dec. 8,1929 Country) Director 80 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10h. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral , or items 23a 21061 7111 Rumford Drive U.S.A. hours after death 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian the Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 XWidowed 4 ☐ Divorced Completed White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Bookkeeper</u> Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Gavnelle Dennison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Brenda Jones / daughter 7111 Rumford Drive. Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 05/26/2010 | Glen Burnie, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD 10135 Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Sofer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatoe disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events signed by the attending physician and deedeched for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.
To the Funeral Director: After this certificate has been sign 1 Ves 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy autopsy performed? 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manner of Death į; 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Certifical Accident Investigation 1 Yes 2 No completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29h, Signa certifie 29d, Date signed (Month, Day, Year) N60842 2010 21225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VAIBHAV 1147 South Hanover Street Baltimore, MD PAREKHI. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician MAY 24, 2010 MILDRED ISADORA GOODE 5:00a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 2126 SOUTHORN RD. BALTIMORE MIDDLE RIVER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 7-24-1930 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. VIRGINIA 79 Director 231-36-5747 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 1√ Yes 2 No Director MD. BALTIMORE MIDDLE RIVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2126 SOUTHORN RD. 21220 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. <u>م</u> Specify: 3 X Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -12-NURSING ASSISTANT HEALTHCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be s 1 and 2 should be fil f Health and Mental H item 27 is marked otl JAMES HUX MINNIE TAYLOR ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2126 SOUTHORN RD. MIDDLE RIVER, MARYLAND 21220 JENKINS (DAUGHTER) SANDRA 20a. Method of Dispa sition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages nent of I permit. Pages Department of Important: If it any Injury or o 1 Burial 2 3 Removal from State Crem 5-19 mer (Specify ENTOMBMENT 6-1-2010 BALTIMORE, MARYLAND 4 Donation KINGS MEMORIAL PARK O-1-2010 BALTIMORE, MARYLA D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signatur 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a, Pa t1. Approximate Interval Between Onset and Death shock Immediate flause (Final diseas for ondition resulting in death) Acciden **Physician** eres rovascul ar /Medical Due to (or as a consequence of): Examiner retension Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-tran Due to (or Box 68760. attending physician for use as the buria law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 DiNo
9 Unknown Month Day Year 5 Other (specify) P.0. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Division of Vital 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 27. Mapner of Dath Other: 4 \sum Nursing Home funeral dir 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 🗌 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI DW 61907

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MD 21221

death (Item 23a) (Type, Print)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Elizabeth Heinmuller Month May 2:25 P_M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Frederick Villa Nursing Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 🕱 F 218-10-9896 MAR 7. 1920 Maryland Director 90 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the M. dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Glenelg Howard MD 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21737 P.O. Box 17 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 hand Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Worker Life Insurance Co. 12 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Patrick Manning Mary Pauline Weeks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Michael G. Heinmuller, P.O. Box 17 Glenelg, MD 21737 son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Loudon Park Cemetery 5/29/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility MacNabb Funeral Home, 301 Frederick Road Catonsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ FIBRILLATION TRIAL disease or condition resulting in death) EARS Medical **Examiner** THEROSCLEROTIE CARDIOVASCULAR DISEASE Securitially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical certificate be Box 68760 as the l IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an sate has l page 2 s autopsy performed death? Hospital or Attending Physician; The 2 2 1 🗌 Yes Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 1 Gratifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number rectioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of cert 29c, License number asanthakuma D42510 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 N. ROLLING ROAD # 108 MD 2122 M. VASAWTHA KUMAN

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ann Herget 2010 9:40 PM Medical May 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Days Hours 11/06/1958 Mary I and Director 215-48-4395 Yrs. 51 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🛣 No MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 403 Amy Drive 21009 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes If Yes, Give 2 🗶 No 1 ☐ Yes 2 🛣 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Non-profit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jack Luckhardt Henry Melba Christina Potz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Herget / Husband 403 Amy Drive, Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 05/24/2010 Hanover, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility ANATCHY 61FTS PSC157RY SIE P HANDVER, NO FLOTE 1233 MONERNEY DO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ a Motostatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? No the negative of the fours after death.

To the Funeral Director: After this certificate has been signed by the atter 3 Ectopic pregnancy 5 Other (specify) Day Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/X/No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, . Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician Month William Stanley Harris 741 PM May 24 2do /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital of Baltimore Baltimore N/AIf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 77 216-28-8076 Director Jan.6,1933 Maryland Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location death with the Marylan 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1□Yes 2□No N/A Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4309 Fernhill Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∏Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 🍇 □ No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Laborer <u>Private Industry</u> 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Spriggs Howard Harris ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4309 Fernhill Ave Baltimore, MD 21215 permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr Margaret Spriggs/Cousin altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 25 ☐ Cremation 3 ☐ Removal from State Greenmount Cemetery 5/27/10Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licens 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 23a. Part 1 _ nter the diseasing or heart failur. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final Physician Due to (or as a construence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-trans and law requires that the death certificate be execu Due to (or as a consequence of): ed by the attending physician detached for use as the buria Box 68760, Physician/Medical 皇 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) P.0. 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>≽</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 1 NO 1 □Yes 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**O 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manne of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

HARRY; William Stank

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 090U AM 4010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL HAVRE MONTGOMERY GROVE de Grace 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗷 F 214-18-2062 Hours Min. SEPT 23 MARYLAND Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits GAITHERSBURG 1X Yes 2 No MARYLAND MONTGOMERY 10e. Street and Number ASBURY METHODIST VILLAGO 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20877 RUSSEU Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ■ Widowed 4 □ Divorced Specify: BLACK Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12)
7TH GRADE College (1-4 or 5+) PRACTICAL NURSE PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ JOHNSON EMORY JUS EBHINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3RL ST NE STEVEN ANDERSON / NEPHEW 2125 WASHINGTON. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place MT AUBURN CEMETERY MAY 224200 BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Survice Licensee 22. Name and Address of Facility 4600 LIBERTY HEIGHTS AVE BACTO, MO 21207 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician toilure piratori disease or condition Medical resulting in death) Due to (o as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit 1120011 Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Other (specify) Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **X**No Other: ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 \square Pending injury Accident Investigation Suicide Could not be ☐ Suicide ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of Reath (Item 23a) (Type, Print) ichael 31. Date filed (Month, Day, Year) 32. Reistra/s Signature State Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland	d / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 1 5 6 7	
it.	Physic /Medi		1. Decedent's Name (First, Middle, Last) Robert	Hendershot 2. Date of Death Day Year 3. Time of Death Man 3 2010 11.12 R.M	
	Exami		4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore City 4c. County of Death	
	Funeral Director		5. Social Security Number UNIC 6. Sex 1 XM 2 □ F 7. Age (In yrs. las 50	st birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Month, Day, Year) Months Days Hours Min. Mar. 4, 1960 9. Birthplace (State or Foreign Country) MAR. 4, 1960 MD	
Maryland	a-f show	ctor	10a. State 10b. County 10c. City,	Town or Location 10d. Inside City Limits 1™Yes 2 □ No	
th with the	23a or 28 st be noti	al Director	10e. Street and Number 1224 ARMSTEAD WAY	10f. Zip-Code 10g. Citizen of What Country? 21205 USA	
036 ours after dea	al", or items Examiner mu	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No It Yes, Give Year or Dates:		
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland	t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2TH College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DRIVER 16b. Kind of Business/Industry TRUCKING	
laryland 2 should be file	and Mental Hygiene. is marked other than aumatic event, the N	Be	17. Father's Name (First, Middle, Last) ROBERT HENDERSHOT 19a. Informant's Name/Relationship (Type. Print)	18. Mother's Name (First, Middle, Maiden Surname) SHARON FELTNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
ore,	nent of Health an nt: If item 27 is ry or other trau		BOYD LONG/BROTHER 20a. Method of Disposition 20b. Plac	1224 ARMSTEAD WAY, BALTIMORE, MD 21205 Ice of Disposition (Name of metery, crematory or other place) Date 20c. Location - City or Town, State	
Baltimore,	Department Important: I any injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice See	ARDENT 05/06/2010 HANOVER, MD 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM.	
	ysician		23a. Part Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	2007–09 EASTERN AVE., BALTIMORE, MD 21231 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death	
	hysician and the burial-transit	/Medical Exa	Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence) Due to (or as a consequence)	nos of):
Box 68	0.0		FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown	eath 3 Ectopic pregnancy	
Records, P.O.	been signed by should be deta	ted by Pl	Part II. Other significant conditions contributing to death but not resulting	ing in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 ☑ No 3 □ Probably 4 □ Unknown	
I Rec	S CV	Completed	25. Was case referred to medical	24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 1 □ Yes 2 □ No	
Division of Vital or Attending Physician: T	this ral d	P B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/ 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home,	26. Place of Death (Check only one) Voutpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) Sb. Time of Injury M Unity 28c. Injury at Work? M 1 □ Yes 2 □ No P. farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,	
To the Hospital or within 24 hours after	Funeral Director: After stelly filled in by the fune		9a. Certifier (check only 2 Medical Examiner: On the basis of examination	dge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
To the	To the comple	Z 2	9b. Signature and title of certifier 0. Name and address of person who completed cause of death (Item 23)	29c. License number RES-000 May 3, 2010	
	Stat Registra	e ³	5 term 23 Sterm 1. Date filed (Month, Day, Year) 32. Registrar's Signature	600 North Wolfe St, Baltimore, MD, 21287	

DHMH 17 Rev 1/2001

amend item 8 per fb e913 3-18-11 yt State of Maryland Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year :50 P M Ernest Lee Jones Jr. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Good SamaritAn Hospita Baltimore 8. Date of Birth Month, 20, Year July 23, 1929 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Days Hours North Carolina 240-34-5850 **Director** 80 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗗Yes 2 ☐ No Mary land Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1030 E. 33rd Street 21218 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or iter ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour popartment of Health and Mental Hygene. Important If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) Steel Worker Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Ardenia Ernest Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernestine Shepherd 3643 Wabash Avenue Baltimore,MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. ¢em. 6/1/201↓ Owings Mills, MD 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Si noture Funeral Subjectionse 5240 Reisterstown Road Baltimore, MD 21215 23a. Paryl. Enter the elsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ septic arthritis Medical Due to (r as a consequence of): Examiner Hemorrhauic shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner Septic shock secondary to Acinetobacter the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?
1 Yes 2 No Month 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à stage renal disease Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an has autopsv Peripheral vasculour After this certificate Yes 2 No 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Hospital Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5-000 05, 22, 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVd Baltimore MD 21239 31. Date filed (Month, Day, Year) Registrar

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The law requires that the death certificate be the l certificate has bector, page 2 sh this

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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: n 24 hours after w...
the Funeral Director: Af

Physician/Medical UNPENDED **AMENDED** 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✔ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obesity 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an autopsy performed? Yes 2 ✔ No 25. Was case referred to medical 26 Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA 2 1 V Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner

29b. Signature and title of certifier

and manner stated

29c. License number

O.C.M.E.

Year

2 No

Day

death?

29d. Date signed (Month, Day, Year)

May 25, 2010

OCME

Yes

Were autopsy findings available

prior to completion of cause of

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day Ye

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year acks 12.10 m arrie Ma-2010 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** City, Town, or Location of Death 4c. County of Death Kegwick Multica Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Funeral 1 □ M 2**X** F 240-46-2060 Director Usual Residence of Decedent or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Page 1 and 2 should be filled within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other terms. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Bace - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married 1 Yes No If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working ife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Be 19b. Mailing Address (Street and Number or 370 Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Fun and ervice censee no 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rhysician/ disease or condition resulting in death) CANCE 0/00 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examiner Due to for as a consequence of,: and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Divísion of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) Yes Z 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 After this certificate has funeral director, page 2: 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation hin 24 hours after deat the Funeral Director, 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatu and title of certifier e signed (Month, Day, Year) 0 29c. License number 29d. Dat DO059056 10 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOID MO Saluja Hop St Wesz 00

State Registrar istrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State of Maryland / I					lental Hy	giene	4 475	1 1
		Registrar 1. Decedent's Name (First, Middle, Last)	Cert	tificate of	Death	-	0.5.1.75	Reg. No.		16611
Physic Med		Marion E. Johnson					2. Date of De Month	ath Day 25	Year 2010	3. Time of Death 7:35 PM
Exam	iner	Season's Hospice		4b. City, Town, Rar	or Location dalls			4c. Count	y of Death altimo	ore
Funera Directo		5. Social Security Number 220–64–3173 6. Sex 7. Age (In yrs. last birt		If Under 1 Yea Months Day		er 24 Hrs. Min.	8. Date of Bir (Month, Da 11/22)		g. Birthp Coun	
nd how	_	Usual Residence of Decedent	yn or Loc:	ation					1.	MD
: Maryla 28a-f s otified	irecto	MD		Balt	imore				[0d. Inside City Limits 1X Yes 2 □ No
s 23a or	Funeral Director	10e. Street and Number 458 Tubman Court		10f. Zip Code 21	201			10g. Citizen of	What Coun	try?
Iryland 21215-0036 uid be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	ğ	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No	lf `	as Decedent of Yes, specify Cul	ban, Mexica	ın, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American II Black, White, etc. Specify: Blace		etc.
altimore, Maryland 21215-0036 mit. Page 1 and 2 should be filed within 72 hours after partment of Health and Mental Hygiene. portant: If item 27 is marked other than "natural", or hijury or other traumatic event, the Medical Examise.	Completed		(Give kir life. DO	nt's Usual Occu nd of work done NOT use retired eacher	during mos	st of workin	g	16b. Kind of B	Business Inc	ŕ
Maryland 2 12 should be filed valth and Mental Hyg 27 is marked other r traumatic event,	To Be	17. Father's Name (First, Middle, Last) Fred Johnson			18. Moth	ner's Name arion	(First, Middle, Elizak	Maiden Surnam eth Cli	nton	
e, Mar and 2 shou Health and tem 27 is m		Sandra Harmon / Sister 45	o. Mailing 58 T	Address (Stree ubman C	and Numb ourt,	er or Rural Balt	Route Number imore,	r, City or Town, S MD 2120	State, Zip C) 1	lode)
Baltimore, Marylar permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		20a. Method of Disposition 1 ☐ Burial 2 又 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of cemeter Final	ry, crema	tion (Name of tory or other pla urney C	rem.		ate 7/2010	20c. Location Woodb	•	•
Balti permit. Departr Importa any inju		21. Signature of Funeral Service License Dorota Marshall	22.1	Name and Addr Mar PO	ess of Facility Land BOX 14	Crema	ation S Baltimo	Services ore, MD	21203	
Pnysician		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	not enter t	the mode of dy	ng, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence or	of):						+	
ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjory	of):						5	
760 :ate be executed physician and the burial-transit	al Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of	of):							
\$760 ficate b g physias the b	Medical	d								
DIVISION Of VITAL RECORDS, P.O. BOX 687 To the Hospital or Attending Physician: The law requires that the death certification to the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	1 3 □ E 5 □ (Ectopic pregnan Other (specify) _	су			23d. Da	te of deliver	ry Day Year
s that the gned by t	ρ	Part II. Other significant conditions contributing to death but not resulting in	n the und	lerlying cause g	iven in Part	l.	23e. Did to	bacco use contr	ribute to the	e cause of death?
ords, require been si should I	leted									ably 4 Unknown
VITAI KECOTGS, ysician: The law requires is certificate has been sig	Completed						24a. Was a autopo perfor	med?		sy findings available ipletion of cause of
VITAI ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	tnatient	Oth	lace of Deat			s T au	in-Act	rient hospice
In OT Iding Phoths. After the funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) inj	ime of njury	28c. Injur	y at	28		ow injury occurre		
DIVISION OT its or Attending Plus after death. In Director: After the ord in by the funeral	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)			res 2 🗆	-	8f. Location (St City or Town	reet and Numbe n, State)	er or Rural F	Route Number,
E Hospita 124 hours E Funeral	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the best of my knowledge, dresh of the desired for the desired forms and/or only one) 1 Certifying Nurse Practioner: To the best of my knowledge, dresh of the desired forms and/or only one)	r investiga	tion in my onini	on death on	curred at the	a timo data an	d place and due	to the enue	lacked we work and (e)e.
To th within To th	_	29b. Signature and title of certifier N S Rycopard M.D.	sago, dou	29c. Licens		-		9d. Date signed		
		30. Name and address of person who completed cause of death (Item 23a) (Ty N. J. Rajapa KSC/M.D. 2335	ype, Print Smit	n Av., 5	-235	S,Balt	imore/	MD, Z1		
Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	b	entel						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Dorothy Hope Kunsman May 7:52 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 1 □ M 2 🕅 F OCt 13, 1926 Months Davs Hours 83 Yrs Director 220-20-5356 Mary Land Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🎇 No Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White "natural", If Yes, Give Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Purchasing Sheet Metal Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Frank Malle Catherine Simmont 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Silkworth, Daughter 324 Ternwing Drive Arnold, Maryland 21012 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State any injury or Metro Crematory Inc. 05/25/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor িশ্লানিরিকিজিজ্জিতিই ety Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Momas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician NEUMONIA disease or condition au Medica resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 No 9 ☐ Unknown signed by the a d be detached f 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has performed? 1 ☐ Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 → patient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. ☐ Homicide within 24 hours after To the Funeral Direct Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

Registrar
DHMH 17 Rev 7/2009

State

Annapolis

Parkway

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ive lisse

31. Date filed (Month, Day, Year)

MAY 2

2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1:53AM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OF MARYLAND MEDIUAL LENTER BALTIMORE N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Hours Min. N. Carolina Director 243-16-6904 88 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 1X Yes 2 No N/AMD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1315 Riggs Ave 21217 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 XMarried Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Specify: Black Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 4th Grade Construction Worker Bestcon Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Sarah unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hattie Keys(Wife) 1315 Riggs Ave., Baltimore, MD 21217 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/27/10 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph H. Brown Jr. 2140 N. Fulton Ave., FUneral HOme Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ NEUMONIA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Director: After this certificate 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 5, 21, 2010 willmour 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENNETH D. EILHENBAUM GREEN 31. Date filed (Month, Day, Year) 32. Regis rar's Signature State Registrar DHMH 17 Rev 7/2009

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AMEND ITEM# 24a, perPHYS, G903, 5/27/2010, ws

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 20 Ben Kornhauser 5:15 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Social Security Number 6. Sex 1 **X** M 2 \square If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Country) **Y17/25/19**11 98 Yrs. 272-07-2526 Director Usual Residence of Decedent or 28a-f shove notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Tes 2 X No PIKESVILLE MD BALTIMORE 5 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? be "natural", or items 23a edical Examiner must be Funeral USA 8911 REISTERSTOWN ROAD, #211 21208 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No
If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 X Widowed 4 Divorced Completed WHITE Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Menta Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Money. **ENGINEER** U.S. GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည KORNHAUSER MARI WINKLER LOUIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THISTEL DELL COURT, OWINGS MILLS, MD 21117 DAVID KORNHAUSER / SON Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HAR SINAI CONG. 05/26/2010 OWINGS MILLS, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Jole 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death End-Stage Dementia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last use as the burialsigned by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has actopsy performe within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? 4 Nursing Home 5 Residence 6 Yother (Specify) 10 Hospital Other: 1 🗌 Yes 2 W No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ns Rajupakse M.n D0057465 5/20/10 2835 Smith Av., 5-235- Baltonore, MD. 21209. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. Rajapakse, M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ay 23,2010 Physician/ May 3:45 A Lerch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1034 Downton Road Arbutus If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Pay Year)
Mar. | 4,1925 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2 🗓 F 85 Yrs. Director 219-14-0906 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director MD Baltimore Arbutus 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 1034 Downton Road 21227 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 0 Completed by 1 Never Married 2 X Married Specify: white 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event the Man Elementary/Seconday (0-12) College (1-4 or 5+) 8 Store clerk Retail sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Gatto Mary Alascio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21227 Russell Lerch-husband 1034 Downton Road, Arbutus 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date XX urial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Zion Cemetary May 27,2010 Elkridge MD 22. Name and Address of Facility Ambrose Funeral Home Inc. Funeral Service Licens 1328 Sulphur Spring Road Rd Arbutus MD 21227 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death MYGLOMA MULTIPLE Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical certificate be IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Dav Year the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CHAONIC OBSTRUCTIVE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \sum Yes Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 To the Hospital or Attending | within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) NA Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifig May 26, 2010 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Armore MO 340

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 11:20 AM Han loon Umarion /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F NIA Mary land Yrs **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified at 1 Tes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Numbe 23a or 21206 items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 2 NO Baltimore, Maryland 21215-0036 "natural", or 1 Yes 2 No þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry i and Mental Hygiene.
is marked other than "naturraumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i 17 More 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date or other place) permit. Pages
Department of
Important: If it
any injury or o etery, crematory 1 Jurial 2 Cremation 3 Removal from State 4 Donation 75 ☐ Other (Spectf⊽ of Funeral Service 4660 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) treme /Medical as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death ed by the attend detached for u Live birth 3 Ectopic pregnancy in the past 12 months? Day Yea Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 Tyes 3 Probably 4 Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 No 1 Yes 1 Yes 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 ☐ Yes 2 X No 1 Nnpatient 2 ER/Outpatient 3 DOA ၉ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred s after death. Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 Accident the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral D

completely filled Hospital 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (check only one) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) မ 2010

DHMH 17 Rev 1/2001

State Registrar 600 North Wolfe St, Baltimore, MD, 21287

pnes

32. Pogistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the

Day,

TIMO

a

31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of M State Registrar	aryland .		ırtment of ⊢ <i>tificate of L</i>			Jiene Reg. No. 🤈 🎧 📗	0 18617
	Dhuninin	~ /	Decedent's Name (First, Middle, Last)	-				2. Date of Dear		3. Time of Death
	Physicia Medic	al	GEORGE EDWARD MAYO					May	22 201	0 7-50PM
	Examin	er	4a. Facility Name (if not institution, give street and number) LOCH RAVEN CENTER			4b. City, lown, or BALTI	Location of Death		4c. County of Di	
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last i	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	g.	Birthplace (State or Foreign
	Director		228-26-2144	83	Yrs.	World Baye	Tiodis Will.	(Month, Day, MAR 25	1927	VIRGINIA
	and show lat	or	10a. State 10b. County	10c. City, To	own or Loc	ation				10d. Inside City Limits
	Maryl 28a-f otifiec	irec	MARYLAND N/A			7	IMORE			1 🏿 Yes 2 □ No
	ith the 3a or t be n	ral D	10e. Street and Number			10f. Zip Code	215		10g. Citizen of What U.S.A.	Country?
	ems 2	Funeral Director	2628 W. COLDSPRING LN 11. Marital Status 12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba		ecify Yes or No-		merican Indian,
30	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at one.	þ	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☑ 3XXWidowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	No	1	Yes, specify Cuba		Hican, etc.)	Black, W Specify: B	
2-003p	hours natura dical E	Completed	15. Decedent's Education (Specify only highest grade completed)	I I	6a. Deced	ent's Usual Occupa	ation	kina	16b. Kind of Busine	ss Industry
121	thin 72 ane. than "	Som	Elementary/Seconday (0-12) College (1-4 or 5	ō+)	Ìife. DC	NOT use retired)	Ü	, I	CATVANTZE	CO
N.	led wit Hygie other ent, th	Be	3rd grade 17. Father's Name (First, Middle, Last)		CHEN	<u>MICAL WOR</u>		ne (First, Middle, I	GALVANIZE Maiden Surname)	CU.
/lan	d be fil Aental arked tic ev	မ	JAMES MAYO				KATTIE	TOWNE		
Maryland	should and it is ma		19a. Informant's Name/Relationship (Type, Print)			•			City or Town, State,	
e,	and 2 Health tem 27		India Mayo/Granddaughter 20a. Method of Disposition	20b. Plac		Lauretta sition (Name of	AVe., B	altimore Date	, Marylan	
altimore,	age 1 ent of nt: If ii	1	1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dogation 5 ☐ Other (Specify)	cem	etery, crem	cemetery or other place	1		·	, MARYLAND
Balt	ermit. F epartm nporta ny injui	1	21. Signet re of Funefal Service Licensee	III.	_	Name and Addres	s of Facility BROWN CO	MMUNITY	FUNERAL H	
_	<u> </u>		234. Part 1. Enter the disease, or complications that caused	d the death. D	112	206 W NOR	TH AVENU	E		Approximate
i	Pnysician/	2 2	shock, or heart failure. List only one cause on each line Immediate Cause (Final	V 10	10	500	JAIAL	/	MC21	Interval Between Onset and Death
در	Medical Examiner		disease or condition resulting in death) aa	consequen	ce of):	arre	T Ju		7.0	
	Examine	e.	Sequentially list conditions, b.	a consequera	no info					-
	ted I Insit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	a consequent	oo oij.					
	cate be executed physician and the burial-transit		that initiated events c. resulting in death) Last Due to (or as	a consequen	ce of):					
3	ate be	edical	d							
200	certific nding use as	n/M	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant			1 = 4 - 1			23d. Date of	delivery
Box 68	sician: The law requires that the death certific certificate has been signed by the attending rector, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Ectopic pregnanc Other (specify)	;y 		Month	Day Year
л. Э.	hat the ed by t detach		Part II. Other significant conditions contributing to death b	out not resultin	ng in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
32,	luires t an sign uld be	ed by						1 🗆 Y	′es 2□No 3□	Probably 4 🕅 Unknown
202	aw rec as bee	Completed						24a. Was a autop	sy prior	autopsy findings available to completion of cause of
Å Y	t The licate h							perfor 1 🗌 Yes		Yes 2 ☑ No
Ital	sician s certif lirecto	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Input	ient 2 🗆 ER	/Outpatien	_ Othe	er:		ence 6 Other (Sp	naciful
ot to	ng Phy fter this ineral c		27. Manner of Death 1 Natural 5 Pending (Month, Da	ıry 28	b. Time of injury	28c. Injury work	y at		ow injury occurred	isony)
ion	ttendii death. stor: Ai	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	un/ - At home	form stra	M 1 🗆	Yes 2 No	29f Leasting (St	tract and Number or	Pural Pouta Number
Division of Vital Records,	al or Al		4 Homicide determined		, lann, sire	et, factory, office		City or Town	treet and Number or n, State)	Hurai Houte Number,
	To the Hospital or Attending Physiciam: within 24 hours after deard and To the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of							
	o the l	ž	only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	best of my kn	owledge, d	leath occurred at the 29c, License			cause(s) and manner 29d. Date signed (Mo	
	->-0		> Well Attouling	DAYSI	tran	- Ds	3642		May 2	42010
	IV		30. Name and address of person who completed cause of o	leath (Item 23	a) (Type, R	rint) D	11A	Rote	GO Mr	2205.00
	Sta	te		ar's Signature		10 01	(6)	1-UCIC V	VIC	2010-
	Registr	ar	MAY 2 7 2010 1	u B	for	On Ked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Physician/ Month MAY Joseph Allen Marques 8:10 AM Medical Facility Name (if not institution, give street and number)
Union Memorial Hospital 4b. City, Town Town, or Location of Death Baltimore 4c. County of Death Examiner N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Days Min. 198-40-3344 XX M 2 D F 56 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD Baltimore Middle River 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 841 Maple Crest Drive 21220 USA . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2XXNo þ 1 KM Never Married 2 Married Maryland 21215-0036 1 Yes 2 XXo Specify: If Yes, Give Specify: white 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) 12 College (1-4 or 5+) Bartender Food & Beverage 0 Be 17. Father's Name (First, Middle, Last)
Americo D. Marques 18. Mother's Name (First, Middle, Maiden Surname) Unknown ည 19a. Informant's Name/Relationship (Type, Print)
Margaret Ferbuson / 19b. Maijing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) er 841 Maple Crest Dr., Middle River, MD 21220 Step Mother 1 and 2 s f Health a item 27 i injury or other Baltimore, Important: If item any injury 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 ; 1 Burial 2 Cremation 3 Removal from State Ardent Crematory or other place 5/26/2010 Hanover Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Victor P. 22. Name and Address of Facility Charles L. Stevens Funeral Home, 1501 E. Fort Ave, Baltimore MD 2 Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY SYND ROME Physician/ ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 16 hours CARDIOGENIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician are as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death ed by the detached g | Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performe 1 Yes 2 No certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗆 Yes 2 X No ၉ 1 📈 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural Acciden Suicide injury 5 Pending ithin 24 hours after death.

the Funeral Director: Af
ompleted filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) MD AT 2438946-H8 MAY 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL BALLIMORE, MD 21218 ANDREEA OUTRU UNION MEMORIAL 2010 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bernard P. Manderville, III 07:06 PM Medical Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death **Examiner** 1 timore Imove 8. Date of Birth

July 4, 1961 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. **XX** м 2 □ ғ Hours Hawaii Known as Bernard Alanderni Maryland 21215-0036 48 223-84-2146 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XXNo Baltimore Reisterstown MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21136 U.S.A. 11 Austin Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces?
XX Yes 2 \(\subseteq \text{No 1985-} Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates. 1989 White XXWidowed 4 Divorced "natural" Completed I Hygiene. other than "natura ent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other th: any injury or other traumatic event, the I Information Technology Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Bernard P. Manderville, Jr. Jane Granger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 20603 Valerie Manderville/Sister 10105 Astill Ct. Waldorf, たたらい Baltimore, N 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date All Faiths rematory & Chapel 1 ☐ Burial XX Cremation 3 ☐ Removal from State 5/28/10 Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) ur eral Service Licensee 22. Name and Address of FacilitEckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CUVal Medical Due to (or as a consequence of): Examiner NED BY MEDICAL Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) transit Hospital or Attending Physician: The law requires that the death certificate be executed TIFICATION APPRO and that initiated events Due to (or as a consequence of): resulting in death) Last ending physician a use as the burial-Completed by Physician/Medical Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day ģ Month Year Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Unknown art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? oumadi 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed death? this certificate Yes 2 2 🗷 No 1 Yes 25. Was case referred to medical examiner?
1 1 Yes 2 No Division of Vital funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗆 Yes 2 🗷 No injury 1 ☐ Natural 2 ☑ Accident 5 Pending 22 2010 14:48 24 hours after death. Funeral Director: A Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be ace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 2113). City or Town, State) filled in by determined MAUSTIN Rd HOME Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 68810 25 2010 her 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bult, more Sharpon MO HOSA. MAC Weintr 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

10-03294

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Leroy Moore		State of Maryland / Department of Health and Mental H 1-For State Registrar Certificate of Death	ygiene Re	eg. No. 2010	18620
Physician Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Leroy Moore	2. Date of Deat Month April 28, 2	Day Year	3. Time of Death 2109 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 5800 Annapolis Road Apt. 706 Bladensburg)	4c. County of Dea Prince Georg	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	8. Date of Birt 09/11, Sept.	h(MM/DD/YYYY) 9. B /1970 9 , 2010	irthplace (State or Foreign country) DC
v any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ryland a-f shov	힎	DC Washington 10e. Street and Number 10f. Zip Code	110	g. Citizen of What Co	1 X Yes 2 No
ith the Maryland 23a or 28a-f show any notified at once.		3001 Bladensburg Rd. NE #704 20018		USA	,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Sive Year 13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto		14. Race - Ame White, etc.	erican Indian, Black,
ours after attural"	2	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v		16b. Kind of Business	
36 hin 72 h e. than "n chical E	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 12 during most of working life. DO NOT use reti Maintenance Engin		N.I.H. Federal	Government
5-00 led with Hygiene I other	۱ د	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, M	faiden Surname)	-
MD 21215-0036 and 2 should be filed within 7 alth and Mantal Hygiens m 27 is marked other than aumatic event, the Medica	90	Leroy Moore, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fig. 1)		_	te, Zip Code)
MD and 2 sho alth and m 27 is	-	Lucy Mae Davis/Mother 3001 Bladensburg			
Baltimore, oemit. Pages I an Department of Hea Important: If ites injury or other tr		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Riverdale Park 5/	Date /11/10	20c.Location-City o	
Balti permit. Departn Import		21. Signature of Funeral Service Licensee 22. Name and Address of Facility La			
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a Gunshot wound of head Due to (or as a consequence of):			Death
	₹ I	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
Jr = = = .	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
S a a a a a a a a a a a a a a a a a a a	<u> </u>	d. UNPENDED AMENDED			
3760, ificate be g physic s the bur		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ncy	23d. Date of deliver	ry Day Year
Box 6876 e death certificate the attending phy ed for use as the by	Sicia	past 12 months? T		None	50, 100
P.O. BGs that the desgned by the adetached for the second by the second by the second for the se		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to	the cause of death?
Division of Vital Records, P.O. and or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach partification: To Be Completed by D	nai		24a. Was a	n 24b. Were a	utopsy findings available
Records, The law requires ficate has been sig		-	autops perform 1 ✓ Yes 2	ned? death?	completion of cause of
ician: 1	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin			
1 of Vi ling Physi After this funeral di	<u></u>	1 Ves 2 No 22. No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	Residence 6 Othe ow injury occurred	er: Scene
Sion Attendig	[[[2 Accident Investigation Apr 28, 2010 2103 hrs	Subject shot	and and Number of D	ural Route Number, City
Division o's spital or Attending Jours after death. neral Director: After filled in by the funer filled in by the funer Certification.		3 Suicide 6 Could not be determined Could not be dete	or Town, Sta		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.			
F \$ F 2 S	1	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mc	onth, Day, Year)
W		30. Name and address of person who completed cause of death (Item 23a)			
Stat	3	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Manth, Day, Year) 32 Pegistrar's Signature			<u></u>
Registra		MAI 18 2010 Census & 1			
DHMH 17 Rev 1/2001	1	OCME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Items 23aPtI,25 per me, 2903,05/27,2010dhb Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3: 20 PM 2010 Luzviminda N Mitchell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 68 Director 345-44-5147 10-10-1941 Philippines Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10h. County d other than "natural", or items 23a or 28a-f shovevent, the medical Examples in the 1XXYes 2 □ No Director MDAnne Arundel Curtis Bay 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21226 Funeral 1522 Popland Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Narried 1 ☐ Yes XX No Specify Specify: Philipino à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10 College (1-4or 5+) Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev ည Maximo Velasco Carolina Nacion 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Frank Mitchell / Husband 1522 Popland Street Curtis Bay, MD 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial XXX Cremation 3 ☐ Removal from State May Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Funeral S 22. Name and Address of Facility Singleton Funeral & Cremation 1 2nd Ave SW Glen Burnie, MD 21061 Services, PA M01220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 WEEKS Immediate Cause (Final ACUTE CORONARY CYNDROME **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 3 WEEKS SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 3 WEEKS INJURY APPROVED BY MEDICAL EXAMINER AWTE KIDNEY Due to (or as a consequence of): Acute Myocardial Infarction Physician/Medical CERTIFICATION IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To . Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

death certificate be executed burial-transit and Division of Vital Records, P.O. B6x 68760, attending physician the as for use the p signed t cate has t page 2 s certificate this After this funeral d ospital or Attending I hours after death. within 24 hours after use....

To the Funeral Director: Aft

death with the Maryland

72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than '

Maryland 21215-0036

altimore,

28a-f show

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Medical

State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number AT 2438946 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMORIAL HOSPITAL, BALTIMORE MD ANDREEA UMION OLARU

31. Date filed (Month, Day, Year) 2010 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5/18/2010 **Physician** 5:30 AM Eleanor T. Maminski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marley Neck Rehablitation Glen Burnie If Under 1 Year If Under 24 Hrs. Hours Min. Arundel Anna 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Year) Months 168-12-8724 87 Director 6/16/1922 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, I'm Medical Event in it. In Intellibut at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📉 No Director MD Ann Arundel Glen Burnie 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 525 Newflied Road 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married Married 2 **X** No 1 ☐ Yes 2 🗓 No Specify: Specify: Caucasian Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 owne Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Ravitis Kubilus Anna ပ Print) Daughter 19a. Informant's Name/Relationship (Type. F 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other trong once. Dolores Maminski 663 Lake Drive Westminster ,MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date /21/2010 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hanover MD A WeatherfordFS PA Ardent Cremation 22. Name and Address of Facility Phillip 2431 East Oliver St Baltimore MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last burial-trar attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) ned by the a detached f 9 Unknown 9 Unknown signed by 1 I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes 2 □ No 3 Probably 4 Unknown Completed cate has been s page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred edical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate ha filled in by the completely

Baltimore, Maryland 21215-0036

Registrar

Medical

31. Date filed (Month, Day,

29b. Signature and title of centifier

29a, Certifier

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

Year) 32. Registrar's Sigr

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ May Eileen 28 2010 Μ. Murphy 4:41а м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 2360 Northcliff Jarrettsville Drive Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 🗶 F Months Days Hours Min Feb 6, 1922 88 216-12-5759 Director Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Md. Harford Jarrettsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2360 Northcliff Drive 21084 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc ð 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 🛛 Widowed 4 🗆 Divorced Specify: Completed White and Mental Hygiene.
is marked other than "natural aumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mente Important: If item 27 is marked any injury or other transcorre 2 Charles Leonard Munson Lillian Arlow Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carolyn M. Lane/ Daughter 2360 Northcliff Drive Jarrettsville, Md. 21084 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Dulaney Valley Mem. 5-29-10 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral License 22. Name and Address (Farithwson Funeral Home, Inc. 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final oulmonar Physician/ OD disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Unknown 9 Unknow Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2 s autopsy death? performe Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 2 Other: 1 🗆 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 0005145 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2010 Perry James Pence 2:23 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Anne Arundel Medical Center</u> Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 - F Days Hours Months (Month, Day, Year) 10/16/1930 Country) Missour Director Yrs 491-30-4365 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's <u>Bowie</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4806 Riverton Lane U.S.A. 20715 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Ş 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumaria. Elementary/Seconday (0-12) College (1-4 or 5+) Communications Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Pence Alma Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Pence / Wife <u>4806 Riverton Lane, Bowie, MD 20715</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 05/24/2010 Anatomy Gifts Registry Hanover, Maryland 22. Name and Address of Facility ANDTOMY CIPTS MICHSTRY 752) whieher Dr. Sie P MANDUER MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 149 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a conse uence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaca o use contribute to the cause of death? Completed by 1 Nes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 HNO Certificate: To e Hospina. in 24 hours after death. the Funeral Director: After this of 1 Doatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) npleted filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of certifier 29d. Date signed (Month. Day, Year) Ø V Name and address of person who completed cause of death (Item 23a) (Type (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #17 & 19a, per Fh G904 6/1/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** PATTERSON 1:00 PM MICHAEI 2010 /Medical HOUSE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ChESAPEAT HARWOOD ANNE HOSPILE ocial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, 6 - 39 Birthplace (State or Foreign Country) Funeral 295-54-6570 10 M 2□ F 56 Min Months Days Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantinar must be notified at ONCE. **Funeral Director** ARUNDEL 6 AM BR: 115 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 11514 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 MYes 2 No
NYes, Give
Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SERVILL 18. Mother's Name (First, Middle, Maiden Surname. 17. Father's Name (First, Middle, Last) Be Wife 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 / 6 5 - 4 AttERson WAY CAMBRILLS DANV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State HANGUER MY AROENI 5/26/10 4 Donation 5 Dother (Specify) Philippu FATHERTORD KS 21. Signature of Furreral Service Licenses 22. Name and Address of Facility BA HO MD 212/3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Me Physician To lake /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 □ Yes 2 ☑No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 MNo completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospice Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death. To the Funeral Director: / 2 🗖 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 158 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 58 of death (Item 23a) (Type, Print) Mighway State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Amend Item Registrar	state of Mary as 23aPtI,II	yland / L , 25 , 27	epartmen 28a-f Certificat	t of H per i e of L	lealth and me, g903 Death	,05/27/2	Olodhb Reg. No.	0	6626
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Rosemary Virgini 4a. Facility Name (If not institution give			4h City	Town or	Location of Dea	<u> </u>	/ 18 46 Cour	ZO/C	
	Examin	er	LORIED (a)	RIVERSI	-		BE	: ICAN	0	H	ARFO	red
	Funeral Director		064-22-1018	□M 2121 F	In yrs. last birt.	hday) If Under Months Yrs.	Days	If Under 24 Hr Hours Mir		orth Pay, Year) 9, 1927	Cou	place (State or Foreign intry) W York
	ryland how		Usual Residence of Decedent 10a. State 10b. County	10	0c. City, Town	or Location						10d. Inside City Limits
	with the Maryland a or 28a-f show	Director	Maryland Harfo	ord	Bel A		Code			10g. Citizen o	of What Cou	1 □Yes 2 X No
	3a or		502 Lloyd Place			10f. Zip	1014			USA		nu y :
	iter death wi	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Deced	dent of His	spanic Origin? n, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	o- 14. F	lace - Ameri lack, White,	
960	a 5		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ∐Yes 2 XNo If Yes, Give Year or Dates:		1 □Yes 2	2 X No	Specify:		Spe	cify: Bl	.ack
Maryland 21215-0036	within 72 hours liene. r than "natural", redict Ex	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	Decedent's Usua (Give kind of wor life. DO NOT us	al Occupa rk done d	ation Juring most of w	orking	16b. Kind of Business/II Mediation		ndustry
212	filed within tl Hygiene. other than rent, the M	Comp	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		Attorn		, 		Arbitr	ation	
and	l be filed ontal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Last)				_		ame (First, Middle		ame)	
aryk	ss 1 and 2 should be filed in the standard that the standard the standard other items 27 is marked other other traumatic event, in	L C	Oliver Wendall Sa 19a. Informant's Name/Relationship (7		19b.	Mailing Address	(Street a		Dunlap Rural Route Numb		vn, State, Zi	ip Code)
	es 1 and 2 of Health of Hem 27 Is r other tra		Marjorie Clarke /						Bel Air,			
nore	Pages 1 nent of H int; If Ite iry or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specify	Hemograi from State		Disposition (Nan y, crematory or o		i	Date -20-10	20c. Locatio		
2 $^{\mathcal{H}}$ \mathcal{E} Baltimore,	permit. Pages I Department of I Important: If ite any Injury or of once.		21. Signature of Funeral Service Licen		per Am	Memori 22. Name an McCom	nd Addres	s of Facility	Home. P.	Α.		ryland
ak たり A Balti	<u>ರ೮೯೮</u> ೦		23a, Jort 1, Enter the disease, or comp	plications that caused the	e death. Do n	1 50 We	st B	roadway	, Bel Ai	r, MD 2	21014_	Approximate
P P	hysician		23a. Part 1. Enter the disease, or comp nock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	stevu	disesse		91	,	,		Interval Between Onset and Death
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大	executed n and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence o	f):			of responden	MEDICAL EXAM	1831	
23a 68760	g 29 3	edical Ex	· ·	a America		,		CERTIFICAT	Other			
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) m §	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		3 ☐ Ectopic p 5 ☐ Other <i>(sp</i>					Month	Day Year
J 00 8	signed by		Part II. Other significant conditions of	ontributing to death but no	•	the underlying ca	ause give	n in Part I.				the cause of death?
$2\sqrt{\xi}$ cords,	been should	leted	DECLY him SIMA	Oi/(for Hip		ure			24a. Was	Yes 2 □ No		obably 4 Onknown opsy findings available
ROSEMARY Division of Vital Record	rne la rate has page 2	Completed by	Perionen Varia	n Sulvaev	_	Periph Disease	era1	Vascu1			prior to co death?	ompletion of cause of 2 ☑No
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\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	fter this	Certification: To	27. Man er of Death Sural 5 □ Pending	28a. Date of Injury (Month, Day, Ye	28b. T	patient 3 DC ime of jury 2	8c. Injury Work		Home 5 Res	how injury occ		ity)
X vision	death. ctor: A y the fu	ficati	2 X Accident investigation 3 ☐ Suicide 6 ☐ Could not be			nown M	1 □ Y	∕es 2 X No		Street and Nu		ral Route Number.
Div	irs after ral Dire		4 ☐ Homicide determined	28e. Place of Injury building, etc. (3					Bel Air	,MD		ral Route Number, oyd Place
Hospital L	e nosp n 24 hou e Fune detely fi.	Medical	29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ✓ Medical Exam	ysician: To the best of m iner: On the basis of ex and manner stated	amination and	death occurred dor investigation	at the tim , in my op	ne, date and pla pinion, death oc	ce, and due to the curred at the time	e cause(s) and e, date and plac	manner as e, and due	stated. to the cause(s)
Tother	To the comp	Me	29b. Signature and title of certifier	44.0		290	License	number		29d. Date sig		
			30. Name and address of person who d	completed cause of death	h (Item 23a) (1	Lype, Print)	7 70	110		May	18, 20	J10
	3		Hi sup fim	25 Jaw	13 1	ane	FIL	16 1	n 2	1078		
	Sta Registra		31. Date filed (Mpnth, Day, Year)	32. Aegistrar's	Signature	parker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PHYALL Day Year BONITA 525 PM May 23 2010 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northwest HOSAITZL Randalls Town Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-7-1971 Birthplace (State or Foreign Country) **Funeral** 1□ M 2 🔀 F Months Days 38 Yrs. Director 219-94-1147 MD Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination ust by redified at 10d. Inside City Limits Director MD Yes 2 No na Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 630 N. Milton Avenue 21205 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 \$ 1 ☐Yes X No Specify: 3 ☐ Widowed 4 【 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Security 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked of any Injury or other traumatic ev Steven Phyall Bonnie Swain ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Leary-Mother 1629 Northbourne Road Balto,MD 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount 5-31-2010 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Bacterema Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Şq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No certificate 1 □Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 🗆 No 24 hours after death Funeral Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier юmpletely (Check only one) within 2 To the F 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Road, Randallstown, MD 21133

Registrar

31. Date filed (Month, Day, Year)

KafrouNI

32. Registrar's Signature Sener S. park

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William Joseph R		sch S	tate of Maryl			ent of	Health a				2	010	16628
Physiciar Medical Examin	1/	Registrar 1. Decedent's Name (First, Midd William Josep								2. Date of De Month May 22,	Day	Year	3. Time of Death 0639 hrs
J.		4a. Facility Name (if not institution Harbor Hospital		umber)		4t	o. City, Town, Baltimore		ation of Death			County of D	
Funeral Director	Į,	5. Social Security Number 215-82-0812	6. Sex	7. Age (In yrs. last bir	• •	If Under 1 Y	ear If	Under 24Hrs Hours Min	. 1		D/YYYY) 9	Birthplace (State or oreign
any	Ī	Usual Residence of Decedent 10a. State 10b. County	1_AM 2F	110	Oc. City, Town					Aug 2	28, 1	.964	Country) Maryland
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2 hour	eted by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	ecify only highest gra			Decedent's	Usual Occup st of working I	pation (0	Give kind of v				ess/Industry
filed within 7. Hygiene.	91	9 17. Father's Name (First, Middle			С	arpen	ter	18.Me		(First, Middle	, Maiden S	,	ction
D 2121 should be f and Mental 7 is marked natic event,	o Be	William J. Rau 19a. Informant's Name/Relations Lisa D. Rausch	ship (Type, Print)						Number or F	ricia l Rural Route No g Sun,	ımber, City	y or Town, S	State, Zip Code)
more, M Pages 1 and 2 hent of Health 2 ant: If item 2's other traum	Ì	20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal f	rom State	20b. Place cremat	of Dispositi tory or othe	on (Name of or place)	cemeter	У,	Date	20c. Lo	ocation - Cit	ty or Town, State
Baltirr permit. Pa Departmer Importan injury or		4 Donation 5 Other S 21. Signature of Funeral Service	pecify: Licensee Thon	nas G	<u> Metro</u> regor	Crem 22. Na Cre	atory me and Addre Mation Frede	Inc.	. 05 acility clety . Road	/26/10 Of Mary	<u> Ba</u> yland	Itimo , Inc	re, Maryland land 21228
Physician /Medical /Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each liffe.			ot enter the	mode of dyin	ng, such	as cardiac o	r respiratory a	rrest, shoo	k, or heart	Approximate Interval Between Onset and Death
	_	or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as b.										
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OX 68 sath certif		3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	1 Live	oirth nant at tim	of pregnancy ne of death		death 3	BEc	ctopic pregna	ncy		Date of del	Day Year
s, P.O. Binites that the designed by the		Part II. Other significant condit	tions contributing t	o death bu	ut not resultin	g in the und	derlying cause	e given i	in Part I.				e to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O Ital or Attending Physician: The law requires that the are after death. The interference After this certificate has been signed by led in by the funeral director, page 2 should be detac	Completed	-							<u> </u>			prior deat	e autopsy findings available to completion of cause of h? Yes 2 No
Vital Recognision: The this certificate director, page	ne O	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 🗸 ER/O	utpatient	_	ce of De Other	eath (Check of	only one) g Home 5	Residen	ce 6C	Other:
IVISION OF Northeading Phather death. Director: After the funeral in by the funeral		27. Manner of Death 1 Natural 5 Pend 2 Accident Inve	ding stigation Fd 5	n, Day,Year) /22/1	0 Fd	Time of Inju	hrs 1		2	28d Describe Subject	how injur	y occurred aled	SUV exhaust
Division E Hospital or Attent 124 hours after death Funeral Director: etely filled in by the	Certification:	4 Homicide dete	rmined (Specify)	other						or Town, Rd Ba]	State) 3 Ltimo	800 H	r Rural Route Number, City awkins Point D
To the Host within 24 ho To the Functional Completely form	<u>iā</u>	(Check only Certifying P	hysician: To the be miner: On the basis and manner:	of examin									
	Ž	29b. Signature and title of certifie			an		29c. Licer O.C	nse num	nber			ate signed (23, 2010	(Month, Day, Year)
OV		30. Name and address of person Russell Alexander MD	Assistant N	/ledical	Examiner	111 F	enn Stree	t, Balt	timore, MI	O 21201	•		
Stat Registra		31. Date filed (Month, Day, Year)	2010 32. R	edistrar's	Signature	ba	No.						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Robert Rock Month May 2010 10:00 at Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5109 Old Court Road, Apt. 325 Randallstown Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-26-3627 1 🛛 M 2 🗆 F Months Hours **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Baltimore MD Randallstown 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5109 Old Court Road, Apt. 325 21133 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Black White etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 1 ☐ Yes 2 X No Specify: Specify: African-American Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other fraumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Burke's 9th Chef Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Hezekiah Rock Kathleen Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Rock/Son 6003 Bellona Avenue, Balto. MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State King Mamorial Park 6-1-2010 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Signatur of Funeral Service Licensee 22. Name and Address of Facility Wlie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed After this certificate funeral director, pag 2 No 2 1 Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: ျပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 1-Natural 5 Pending Accident after death Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year)

Registrar

State

30. Name and address of person who completed

31. Date filed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible: State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mah 12:30AM obeson Medical Examiner institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Stree exinato Himore 7. Age (In yrs. last birthday) 8. Date of Birth

Jan. 23,192 **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign Months 1 🗆 M 2 🔀 F Country) Director Yrs. 28a-f shov 10a. State 10b. County the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No rove 10e. Street and Number 10g. Citizen of What Country? Funeral 21229 permit. Page 1 and 2 should be filed within 72 hours after death 10 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner musus injury or other traumatic event, the Medical Examiner musus injury or other traumatic event, the Medical Examiner musus injury or other traumatic event, the Medical Examiner musus injury or other traumatic event, the Medical Examiner musus injury or other traumatic events. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐ Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working dife. DO NOT use retired 16b. Kind of Business Industry College (1-4 or 5+) Be Middle, Last. 18. Mother's Name (First, Middle Maiden Surname) ည Street and Number or Rural Rou 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremeter) or other Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) imore re of Funeral 🕏 rvice License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) tue to (or as consequence of): Examiner Sequentially list conditions, it any, saumy to immediate cause. Enter Underlying Due to (or as a consequence of). Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year cate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature

State Registrar 31. Date filed

Registrar's Signa

License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death (First, Middle, Last) **Physician** 2010 /Medical Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner 9. Birthplace (State or Foreign Under 24 Hrs. If Under 1 Year Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Year) Hours Min. 1 □ M 2 🖫 F **Yrs** Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. Chy. Town or Location 10a. State "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Funeral Director moR 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2:☑ If Yes, Give Year or Dates: Never Married 2 Married Specify: B/ACIC Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental ဥ Unk 19b. Mailing Address (Street and Number or Rural Route Namber, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) of Health a 10 10 Item 27 20b. Place of Disposition (Name of cemetery crematory or other) Location - City or Town, State Date 20c 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ± 5 Department or Important: If any injury or once. 4 Donation 5 □Other (Specify) 21. Signatur of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each sine. Approximate
Interval Between
Onset and Death
Unicum Immediate Cause (Final **Physician** heumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): \mathcal{P}_{I} Chards, \mathcal{P}_{I} Division of Vital Records, P.O. Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mor 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 Probably 1 🗌 Yes 2 🗌 No Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 25. Was case referred to nedical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Medical Certification: To 1∐Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Matural 1 ☐ Yes within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 2010 BP9619430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sanjay MHAP 31. Date filed (Month, Day, fle Hani 700 Caron Avenue Year) 32. Regi State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ivi	aryıarı	-	artment of F tificate of L		wentai n	giene Reg. No	211111		16632
	Diversionis	/	1. Decedent's Name (First, Mi	ddle, Last)						2. Date of D	eath			3. Time of Death
	Physicia Medio			ouise	Smi	th				Month May	Da			11:23 A ^M
	Examin	er	4a. Facility Name (if not institu		eet and number)			4b. City, Town, or	Location of Dea	th	4c	. County of De	eath	
	Funeral		Gilchrist Hos 5. Social Security Number	pice 6. Sex	7. Aq	e (In vrs. la	ast birthday)	Towson If Under 1 Year	If Under 24 Hrs	8. Date of B		Baltimo		ace (State or Foreign
	Director		196-44-2578		M 2 🕱 F	57	Yrs.	Months Days	Hours Min		71 ⁹⁵ 2	2 Pe	nns	ylvania
	and show	ō	Usual Residence of Decedent 10a. State 10b. Cou	nty		10c. City	, Town or Loc	ation					100	d. Inside City Limits
	Maryla 28a-f	Director	MD Hov	ard		Co.	lumbia							1 X Yes 2 ☐ No
	a or 2	i Di	10e. Street and Number				-	10f. Zip Code	-		10g. Cit	tizen of What	Country	y?
	h with ns 23 nust	Funeral	7170 Attic Wi					21045				S.A.		
	r deat or iten iner i		11. Marital Status 1 ☐ Never Married 2 🔀 I		2. Was Decedent I Armed Forces?		i. 13. V	/as Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	specify Yes or No to Rican, etc.)	-	14. Race - Ar Black, Wh		
036	s afte ral", c Exam	ed by	3 Widowed 4 Divor		1 ☐ Yes 2 🔀 If Yes, Give Year or Dates,	No	1	☐ Yes 2 🗷 No	Specify:			Specify:	Whi	te
2-0	should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Completed	15. Dece (Specify only hi	dent's Educ	ation		16a. Deced	ent's Usual Occupa	ation	while e	16b. K	ind of Busines		
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Σ			Michael Raymo	nd Sm	ith / Sp	ouse		Attic Wi						
ore	e 1 ar : of Hk If iter or oth		20a. Method of Disposition 1 D Burial 2 D Cremati	on 3 🗆 Re	moval from State			sition (Name of atory or other place	e)	Date	20c. Lo	ocation - City	or Town	ı, State
Ē	t. Pag tment tant: tant: jury c		4 ☑ Donation 5 ☐ Othe		- Total Totale	Ana		Ets Registr	y 05/	24/2010	Han	over,	Mar	yland
Baltımore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to		21. Signature of Funeral Service	e Licensee	ato			Name and Addres						2026
			23a. Part 1. Enter the disease	or complic	ations that caused	the death		the mode of dying				1) 2000		pproximate
- p	าเพราะเลก	0. 19	shock, or heart failure. Li Immediate Cause (Final	st only one	cause on each line	C100		e c					l Ir	nterval Between Inset and Death
)	Medical		disease or condition resulting in death)	a .	Due to (or as a	a conseque			ar ce	<u> </u>			18	lays
777	Examiner	_	Sequentially list conditions,	b.										
	D ##	nine	if any, leading to immediate	2	Due to (or as a	a conseque	ence of):							
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2/00	ricate ig phy as the	Medi	VE 551441 5	_ u.									+	
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POX	r requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 🗖 No 9 ☐ Unknown		4 Pregnant at 9 Unknown			Other (specify)				Month	Da	ay Year
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Records,	aw rei as be 2 shc	ple								24a. Was		24b. Were a	utopsy	/ findings available pletion of cause of
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VItal	certifi	m	25. Was case referred to medic examiner?		pital:			26. Pla	ce of Death (Che		-3.5			
> Io	r this	욘	1 Yes 2 X No 27. Manner of Death		1 Inpatie		R/Outpatient 28b. Time of	3 DOA Other	4 ☐ Nursing I	dome 5 Resi			ecify)	yospice
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- 10 - 12	withii To th		29b. Signature and title of certi		-100	10 10		29c. License	number		29d. Dat	e signed (Mon		
			▶ 1 Melissa	gw	of C	KAP	,	121	2597	3	Me	ry 2	116	2010
ļ	81		30. Name and address of person	NOCK	CRAP	6	7011	Vi CHar	les St	3 Bal	to	mo	21	1204
	Stat Registra		31. Date filed (Month, Day, Year MAY 2	7 2010	32. Pogistra	r's Signatu	re A La	aked						

10-03849	
Tracy A. Smith	

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se	Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
	State of Manyland / Department of He	

		1- For State Certificate of Death		Reg. N	No.	
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last) Tracy A. Smith	Mor	e of Death nth Da y 19, 2010)	3. Time of Death 2252 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location Baltimore Washington Medical Center Glen Burnie	of Death		4c. County of Death Anne Arundel	
Funeral					1066 Foreig	
Director		253-43-0464 1 M 2 F 43 Yrs. Months Days Hour	rs Min.	1-23-		untry) GA
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show any <u>d at once,</u>	ē	MD Anne Arundel GLEN BURNIE				1 Yes 2 No
e Mary or 28a-	Director	10e. Street and Number 426 D. Secluded Post Circle 21061		10g. (Citizen of What Cou	ntry?
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once.		11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori				can Indian, Black,
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urs afte tural",	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give	kind of work do	ne 16	Specify: b. Kind of Business/I	ndustry
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) B A Degree Correctional Of		5	State of	MD
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	mo.	D II Degree	er's Name (First,	Middle, Maid	en Surname)	
21 be fil mtal B	Be		Bernith			
MD 21 id 2 should thth and Me m 27 is ma	٩	19a. Informant's Name/Relationship (Type, Print) Bernitha Vaughn -Mother 19b. Mailing Address (Street and Nur 917 E. 40th S			, City or Town, State nnah, GA	
		20a. Method of Disposition (Name of cemetery,	Date	20	c. Location - City or	Town, State
imol Pages nent of ant: It		4 Donation 5 Other Specify: Catholic Cemetery				, GA
Baltimore, permit. Pages I and Department of Heal Important: If iten		21. Signature of Funeral Service Licensee 22. Name and Address of Facilit 1101 E. Nor			st F/H Balto,	MD 21202
Physician	-	23a. Part li-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a failure. List only one cause on each line.				Approximate Interval 8etween Onset and
/Medical Examiner		Immediate Cause (Final disease a. Sepsis				Death
- Ar		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b. Neisseria Meningitis infection				
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
ed sit	Examiner	events resulting in death) Last Due to (or as a consequence of):				
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8760, tificate be ng physici as the buri		PI line a-b, 27, pe rME g904 (IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d. Date of delivery	
Sox 687 leath certific e attending p	cian	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	ic pregnancy		Month D	ay Year
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O Of Vi ding Physi After this funeral di	: To	1 ✓ Yes 2 No III illipation 2 ✓ Ervourpation 3 DON 4 27. Manner of Death 28. Injury at Worl (Month, Day, Year) (Month, Day, Year)			injury occurred	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Could not be determined (Specify)		cation (Stree Town, State)		ral Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl				
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated. 29b. Signature and title of certifier 29c. License number			place, and due to the d. Date signed <i>(Mor</i>	
	~	295. Signature and the or certifier O.C.M.E.			ay 20, 2010	, 20,, . 001)
0		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltime	ore, MD 212	L 201		
	tate	31. Date filed (Month, Day, Year). 32. Registrar's Signature				
Regis	trar	MAY 27 2010 Berown B. Jackel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month doju Harolo 0507 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner -angbon farm Circle ANNE den If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 123-22-8233 Months Days Hours Min. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Evanning must be notified at 10d. Inside City Limits MD Director odent 1 Yes 2 □ No ON 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? an C-DON FARM 5. by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 195/ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7: h and Mental Hygiene. 7 **Is marked other than "**n College (1-4or 5+) EXTERMINATOR 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, 1 and 2 should be Health and Mental age-EL NE other traumatic 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trai 36 Langbon Farm Circle Odepton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □Other (Specify) CEM: 5/25/2010 21. Signature of Funeral Service License 22. Name and Address of Facility Funeral GUILTORD ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only and cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician statu /Medical Examiner removasa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.0. the 9 Unknown 9 Unknown by signed the det Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2: autopsy certificate performe Division of Vital 2 No 1 □Yes 2 director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \subseteq Nursing Home 5 Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation Natural Accident death. after death

Director: / 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft **e Funeral Di** Iletely filled ir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mill Blus #330 2401 31. Date filed (Month, Day, Year) Registrar's Signatu State Registrar

DHMH 17 Rev 1/2001

10-03814 Esta Stout

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 16635

		Registrar Certificate	e of Death	Reg. N	lo
Physic Ledical Exam				2. Date of Death Month Day May 16, 2010	y Year 3. Time of Death 2245 hrs
		Shady Grove Adventist Hospital	4b. City, Town, or Location of Deat Rockville	n .	4c. County of Death Montgomery
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 M 2 F 87	y) If Under 1 Year If Under 24Hr Months Days Hours Min		M/DD/YYYY) 9. Birthplace (State or Foreign Country)Kentucky
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I		1,707,732	10d. Inside City Limits
*	tor	MD Montgomery	Rockville		1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	l Director	8 Baltimore Road	10f. Zip Code 20850	10g. C	itizen of What Country? USA
or death wit	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc. White
ırs afte ural", miner	by	or Dates:	Yes XX No specify: edent's Usual Occupation (Give kind of	work dono	Specify: WITTLE Kind of Business/Industry
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nean of Heath and Mental Hygiens and miss. If the many is marked officer than "natural", or items 23a or 28a-f she mit. If item 77 is marked officer than "natural", or items 23a or 28a-f she mit. If item 77 is marked officer than "natural", or items 23a or 28a-f she mot fired at once or other traumatic event, the Medical Examiner must be notified at once	ompleted		ng most of working life. DO NOT use ret Welfare Departmen	ired) (City of Cincinnati/ Hamilton County
21215-0 21215-0 wuld be filed w Marked offic c event, the N	BeC	17. Father's Name (First, Middle, Last) B.J. Caudill	Cora Mu		
MD 2. Id 2 should Ilth and Man 27 is man and m	P _C	Sandra Arena / Niece	ailing Address (Street and Number or 9545 Laguna Drive	Rural Route Number, Gaithersh	City or Town, State, Zip Code) Ourg, MD 20879
Baltimore, Dermit. Pages 1 an Department of Hea Important: If iter		1 Burial 2 Cremation 3 KRemoval from State crematory Spring	sposition (Name of cemetery, or other place) Grove Cemetery	5/27/10 Ci	Location - City or Town, State
Baltimo permit. Page Department of Important: injury or oth		21 Signature of Funeral Service Licensee Victor P. Doda	22 Name and Address of Facility Charles I Stevens 1501 East Fort Ave	Funeral I	Jome, Inc Limoré MD 21230
Physician //Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enfailure. List only one cause on each line.	ter the mode of dying, such as cardiac of	r respiratory arrest, sh	nock, or heart Approximate Interval Between Onset and
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	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause C. b. Due to (or as a consequence of): c.			
tecuted and transit	Examiner	events resulting in death) Last Due to (or as a consequence of): d.			7 =
<u>a a a</u>	n/Medical	X UNPENDED ☐ AMENDED 23a,PII,27,28a-f,	per ME g907 9/29/1	O TT	
∞ ⊕ ≅ ≋ [23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death	Fetal death 3 Ectopic pregna Other (Specify)	125	3d. Date of delivery Month Day Year
Box 6. he death cert the attendii	Physicia	1 Yes 2 V No 9 Unknown 9 Unknown			
S, P.O	Ē	Part II. Other significant conditions contributing to death but not resulting in the Right hip fracture with complicat			o use contribute to the cause of death? No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 6 tal or Attending Physician: The law requires that the death cert safter death. al Director: After this certificate has been signed by the attendited in by the funeral director, page 2 should be detached for use.	Completed			24a. Was an autopsy performed?	
tal F cian: certifi ector,	Be	25. Was case referred to medical examiner? Hospital: Inpution 2 ER/Output	26.Place of Death (Check of		
n of Viding Physi	리	1 ✓ Yes 2 No Nospital: 1 Inpatient 2 ✓ ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time		g Home 5 Reside	
	cation	1 Natural 5 Pending Rd 5/16/10 unk	1 Yes 2 X No	subject fe	11
E 8 5	Certification:	3 Suicide 6 Could not be determined Could not be determined (Specify) Hospital -	street, factory, office building, etc. Adventist bedroom	28f. Location (Street a or Town, State) 9 Dr. Rockvi	and Number or Rural Route Number, City 1901 Medical Center 11e, MD
To the Hos within 24 h To the Fur completely	edical	29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death or one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ccurred at the time, date and place, and tigation, in my opinion, death occurred a	due to the cause(s) are the time, date and pla	nd manner as stated. ace, and due to the cause(s)
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.	r	Date signed (Month, Day, Year) y 19, 2010
		30. Name and address of person who complete cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltimore	. MD 21201	
Sta Regist	ate rar		park	2.20.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 10:15PM Smith ichard May 201C /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City Town, or Location of Death Examiner beasons Hospice of Northwest Hospital Landallstown Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days 704.18.9615 11 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, In Marical Exeminar aust be notified. Yes 2□No Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number USA 4110 Springdale Avenue 21207 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify. Black ģ 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Department of Health and Montal Hygiene. Important: If item 27 is marked other than "nation injury or other traumatic event. In any once. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) House Westing Dispenser 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mack Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garden Drive Windsor Mill, MD 21244 8116 Milford Kichard E Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2010 Winder Mill, MD King Memorial Park 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Vaughin C. Greene Funeral Services 8728 Liberty Road Randwotown MD 21133 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ome **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed .24b. Were autopsy findings available prior to completion of cause of death? autopsy performe this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director. Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAZTIMONE, 40 21708 W. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		Amend #26 Please Type or F	rint in Blac	k Indelible In	k. Ensure All Copi Health and Mental H	es Are Legible) .
		State Registrar		Certificate of I		Reg. No.	16637
Physici Med		1. Decedent's Name (First, Middle, Last) Robert J	toffe	1	2. Date of	Death Pay 2 Year	3. Time of Death,
Exami		4a. Facility Name (if not institution, give street and number Baltimore Washingto	1000.04	2 /1-	r Location of Death	4c. County of De	ath 0 - 1
Funera Director			Age (In yrs. last birth	hday) If Under 1 Year	If Under 24 Hrs. 8. Date of Hours Min.	Birth 9. B 0/1936	irthplace (State or Foreign ountry) MA
and show at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town		1 05/2	71730	10d. Inside City Limits
ne Maryk or 28a-f s notified	Director	MD Anne Arundel	Mil1	Lersville			1 ☐ Yes 2 No
th with tl ns 23a c must be	Funeral	8350 Sycamore Road		21108	3	10g. Citizen of What C	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 Never Married 2 M Married 1 Never M M M M M M M M M M M M M M M M M M M	es? No	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Orlgin? (Specify Yes or N an, Mexican, Puerto Rican, etc.) Specify:	o- 14. Race - Am Black, Whi	te, etc.
215-in 72 ho e.e.man "nat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4		Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	during most of working	16b. Kind of Business	s Industry
2 21 sq with Hygien ther th	Be C	12 17. Father's Name (First, Middle, Last)	,	Master Plum		P1umb	ing
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", on any injury or other traumatic event, the Medical Exam prote.	101	Clayton Stoffel				ibray	
hd 2 sho lealth an m 27 is ner traur		19a. Informant's Name/Relationship (<i>Type, Print</i>) Mrs. Patricia Chenoweth/Da		Mailing Address (Street a	and Number or Rural Route Num 19 Court Gar	ber, City or Town, State, Z ${ m nbrills}$, ${ m MD}$	ip Code) 21054
more age 1 a ent of H nt: If ite y or oth		20a. Method of Disposition 1 ፟	ate cemetery	Disposition (Name of y, crematory or other place	Date Date 17	20c. Location - City o	
Baltii permit. P Departm Importar any injur once,		21. Signature of Funeral Service Licensee	GIER II		ss of Facility1 2nd Aver	Glen Burn nue SW Glen	
<u> </u>		23a. Part 1. Enter the disease, or complications that cau	sed the death. Do no	Singleton	<u> Funeral & Cre</u>	nation Servi	ces, PA Approximate
Ph sician/	8 7	shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition resulting in death)	ungestiv	e heart	failure	i	Interval Between Onset and Death
Examiner	<u>.</u>	Sequentially list conditions, b.	as a consequence of	once Car	failure Liomyopat	hy	
e executed sian and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	as a consequence of				
760 cate be exe physician a s the burial-		resulting in death) Last Due to (or	as a consequence of	ŋ: 			
68760 ertificate b ding physi se as the b	/Mec	IF FEMALE: 23c. If yes, outcome	no of avocation				
ords, P.O. Box 68760 requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Physician/Medical	in the past 12 months?	th 2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у	23d. Date of de Month	blivery Day Year
	by	Part II. Other significant conditions contributing to deat	h but not resulting In	the underlying cause giv	2001 510	tobacco use contribute to	
av av	Completed				per	opsy prior to death?	ntopsy findings available completion of cause of
of Vital Re Physician: The Priticate Pral director, page	Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital:		100	ace of Death (Check only one)		
Of V ng Phy fter this meral d	ite: To	27. Manner of Death 28a. Date of i		patient 3 LPDOA	4 U Nursing Home 544 Tec	how injury occurred	cify)
SION Attendii r death. ector: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			Yes 2 No	(Street and Number or Ru	ral Route Number
DIVI pital or ours afte eral Dire filled in I		building,	etc. (Specify)	-0	City or To	wn, State)	
DIVISION OF To the Hospital or Attending P Within 24 hours after death. To the Funeral Director, After t completed filled in by the funeral	Medical	(Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To t	f examination and/or	investigation, in my opinio dge, death occurred at the	n, death occurred at the time, date time, date and place, and due to	and place and due to the	cause(s) and manner stated
5 ≥ ≥ 0		29b. Signature and title of certifier	m	29c. License		29d. Date signed (Monti	
6+11		30. Mene and address of person who completed cause of the firey Atkinson	no 80		e Huy Pas	May 2	2//22
Sta Registra	_	31. Date filed (Month, Pay, Year) 32 Region 32	strar's Signature	bare	7		
DHMH 17 Rev 7/20	000		1 60	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20ÎÖ Michael Bryan Sunderland, Jr. May 8:35P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 22 Leeds Road Hanover Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Aug. 28,1935 1**X** M 2 □ F Days Hours Min Director 219-30-6643 74 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD 1 🗆 Yes 2 😾 No Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22 Leeds Road 21076 U.S.A. death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married X Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other tranmetr. Elementary/Seconday (0-12) College (1-4 or 5+) General Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ Michael Bryan Sunderland, Sr. Gertrude Katherine Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Loretta D. Sunderland/Wife 22 Leeds Road 21076 Hanover, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 06-03-2010 Crownsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final arcinoid Onset and Death Physician/ disease or condition resulting in death) 0 YEURS Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Pregnant at time of death 5 Other (specify) detached the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be det 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: မ 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this To the Funeral Director: After thu completed filled in by the funeral to 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural work? 1 \square Yes 2 \square No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after or To the Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

X State

Registrar

29b. Signature and title of certifier

-cad won

s Signature

M.D

N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Baltimore MD

29d. Date signed (Month, Day, Year)

2016

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland, 29 epartment of Health 63 com collected by the state of Maryland and State of M Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Day 20 (0) Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location 4c. County of Death BATIMORE WASHINGTON MEDICAL CRAFF PHINE Your alen 8. Date of Birth 9. Birthplace (State or Foreign North Carolin Age (In yrs. last birthday) If Under 1 Year Funeral 1 M 2 □ F Months Hours Director Usual Residence of Decedent or 28a-f show 10d. Inside Çity Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 ☐ No more 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ON 12. Was Decedent Ever in U.S. Armed Forces?

1 ✓ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be ner's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Majden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre et and Number or Rural Route Number, City or Town, State, Zip Code) Somer VI resham 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses hmore Nationa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CYEZ AND LUNCS Physician/ ARCINOMA disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of NAPROVED BY MEDICAL EXAMINER cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month 4 ☐ Pregnant at time of death g ☐ Unknown 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Deep Vein Thrombosis, Subdural Hematoma, Dementia 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Hospital: Other: ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, 28b. Time of injury a 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 01/31/2010 Subject fell. Unknown M 2 X Accident 2**X** No 1 Yes Investigation after deat Director: 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2317 Edmondson Ave Baltimore, MD 21223 4 Homicide determined building, e e Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I mpleted cause of death (Item 23a) (Type, Print) Burnie drive 4105 Miral 31. Date filed (Month. Da State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea **Physician** 1938 16 2010 ROTGE /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore
If Under 24 Hrs. Ho Birthplace (State or Foreign Country) If Under 1 Year Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days **№** M 2□ F Min. 81 NC Director 219-28-5214 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at 1 Tyes 2 No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21202 1413 Townway Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Black à ₩ Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry th and Mental Hygiene.

7 is marked other than "natul traumatic event, the Project Elementary/Secondary (0-12) Wood worker Cabinate Maker 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNK Sr George Stanback ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) daughter 1413 Townway Ct Balto Md 21202 Stanback Pamela other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ţ, Department of Important: If It any Injury or o P☐ Burial 2☐ Cremation 3☐ Removal from State Burial 2 La Greinage...

4 Donation 5 Other (Specify) 5/24/10 Balto Md Garrison Forest 22. Name and Address of Facility Ph. II 1 PA. WEATH ELFOLDES 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5+ BA 4. MD 21213 Approximate Interval Between Onset and Death Immediate Cause (Final ANDIOPUL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ARDIOMYC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Physician/Medical the attending pl IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 3 Probably 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform of Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 1∡ Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🔲 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 24 the 29d. Date signed (Month, Day, Year) 29c. License number 00040763 29b. Signature and title of certified who completed cause of death (Item 23a) (Type, Print)
14 MFD. CTK. 10 NOTH GREEN SHEET BALT. MD. 2120 30. Name and address of perso 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/200

ORIGINAL

Amend #30 per 10 Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death VERA MARIE STILL Vera Miriam Still 20 ay 2010 ar MAY Physician/ 5:05 P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **MONTGOMERY** SILVER SPRING HOLY CROSS HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours ZÉCHOSL<u>OVAKIA</u> 1 - M 2 X F 86 062-30-0865 Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County filed within 72 hours after death with the Maryland items 23a or 28a-f sho er must be notified at Funeral Director SILVER SPRING 1 🗌 Yes 2 🗶 No **MONTGOMERY** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20906 14508 HOMECREST ROAD, APT. 428 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten edical Examiner r Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: WHITE Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education permit. Page 1 and 2 should be filed within 72 Pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Market once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **TEXTILES CLERK** 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ KALMAN LEFKOVITS MARIANNE ALTSCHUL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4402 B 18TH STREET, SAN FRANCISCO, CA 94114 19a. Informant's Name/Relationship (Type, Print) NURITH STILL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1) Burial 2 Cremation 3 X Removal from State 4 Donation 5 DOther (Specify) FOREST GREEN CEMETER 105/23/2010 MORGANVILLE, NJ 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 21. Si heture of Funeral Service Lio 450 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MONTHS Immediate Cause (Final Ph_sician/ PANCREATIC CANCER disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) LIVER METS fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sentitions in deeth). Examine Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown TERMINAL DELIRIUM HYPERCALCEMIA 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PARKINSON'S DISEASE, DEMENTIA s certificate has be lirector, page 2 s autopsy perform Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, B B examiner? Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify) 1 🗆 Yes 2 Z-No 1 1 Impatient 2 I ER/Outpatient 3 I DOA မြ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d Describe how injury occurred iniury 1 X-Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Supanich RSM NO 12010 D0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 121 MD 1500 Forest Glen Rd, Rm 727 Silver Spring, MD 20910 Barbara Ann Supanich, 31. Date filed (Month, Day, Year) 32. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Andrea Christine Tilley State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Time of Death Month Day May 25, 2010 Medical Examiner Andrea Christine Tillev 0924 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c County of Death Upper Chesapeake Medical Center Harford 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or ForeignOklahoma Country) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Director Months Days Hours 115-68-2522 40 1 M Usual Residence of Decedent any 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 X No Maryland Harford Forest Hill Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
anti: If item 27 is anarked other than "natural", or items 23a or 28a-f sho of other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 1623 Ross Road 21050 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 X Married White etc 1 Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: White Specify ð 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas A. Bennett Clara L. Havs မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin L. Tilley, Husband 1623 Ross Road Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Tremation 3 Removal from State Department or Important: injury or oth Metro Crematory Inc. 05/27/10 Baltimore, Maryland 4 Donation 5 Other Specify Signature of Funeral Service License Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor **Physician** 23a. Part I. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line. /Medical Death Immediate Cause (Final disease a Cardiac arrhythmia Examiner or condition resulting in death) Due to (or as a consequence of): b. Fibrous interruption of the right bundle branch of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence or). cardiac con uclion sys em (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last requires that the death certificate be executed led by the attending physician and detached for use as the burial - trans lan/Medical X UNPENDED AMENDED PI 27, per ME g905 7/22/10 TT line a-b, Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death past 12 months? Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No ✓ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No 27. Manner of Death After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Director: 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 28f. Location (Street and Number or Rural Route Number, City To the Funeral Dir 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and t 29c. License number 29d. Date signed (Month, Day, Year) 9 O.C.M.E. May 26, 2010 -00 oK 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

OCME

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Taylor **Physician** Larry Raymond 5/24/2010 8:00pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Absolute Assisted Living Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/21/24 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Social Security Number 028-28-3580 **Funeral** Days Hours Min XXM 2 F Months 86 Director Canada Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "natural", or items 322 and any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Montgomery Rockville XXYes 2 □ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14431 Traville Garden Circle #316 20850 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married XX Married 1 □Yes XXNo þ Specify. white Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembler Tools 18. Mother's Name (First, Middle, Maiden Surname) Georgie May Maharney 17. Father's Name (First, Middle, Last)
Raymond Enos Taylor Be ဥ 19a. Informant's Name/Relationship (Type. Print)
Doris Taylor/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2085014431 Traville Garden Circle #316 Rockville MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Elm Grove Cemetery: 5/31.2010 Steam Mill, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 DNo 1 ☐ Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 6 MOther (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year)
MAY 25, 20/0 29b. Signature and title of certifie 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Rockville MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Champlan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 9:55 A MAY Bronson E. Thompson Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Catonsville Summit Park Nursing Home 8. Date of Birth
(Month, Day, Ye)
Dec. 24, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year 1921 Days 1 🖾 M 2 🗆 F Hours 88 Maryland **Director** 217-14-1015 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No MD Dayton Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21036 4848 Green Bridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married XYes 2 No 21215-0036 White Yes 2 No Specify: Specify: If Yes, Give Completed 3 X Widowed 4 Divorced WWII Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Once. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Route Salesman Be more, Maryland Page 1 and 2 should be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mary T. Harrison Willis Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3213 Ryerson Circle; Baltimore, MD 21227 19a. Informant's Name/Relationship (Type, Print) Sue Shipley Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State Atlantic Crematory 5/27/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Licensee C 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac arrythemias disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 545 theroscleron c heart disease Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury B OUT ENQUERIES CT) U or Attending Physician: The law requires that the death certificate be executed Chrenic atrial the attending physician and hed for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last 1 year Physician/Medical Chronic penal vision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 2 No g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed' 1 Yes 2 No After this certificate funeral director, pag Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 3 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA s after death.
I Director: After this of in by the funeral di 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Vithin 24 hours are
To the Funeral Dir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D30494 5/20/10 220 KDEHIM

State Registrar

THOMPSON

DHMH 17 Rev 7/2009

716 maiden chaice lane Calonerille MD 2126

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

Registrar's Signature

DOSAIMO

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:31 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Freedom Way East Dundalk Baltimore Care Home . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ₺ M 2 🗆 F Hours Ap(11 D1/8 , 1926 213-20-6327 84 Maryland **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1102 Druid Hill Avenue 21201 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ò cook merchant seaman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Edward Tutt Bessie Gray Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Hobson/sister 827 Arlington Avenue #504; Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) o Funeral Service ²²Name and Address of Facility Board; 655 W. Baltimore Street Baltimore, Maryland 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Interval Between Onset and Death Chronic Obstructive Pulmonary Immediate Cause (Final Ph sician/ disease or con-- Years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of: or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 2 No the should be detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has b.
completed filled in by the funeral director, page 2 sl Chirrhosis performed? Yes 2 No Hypertension 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 뎯 2 🕱 No Other; 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ASS x ted 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after o 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0035363 son who completed cause of death (Item 23a) (Type, Print) 10 N. Greene St. Baltimore, MD 21201 BVAMC State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene per me, g903,05/27/2010dhb Certificate of Death

Registrar

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Veillette Month May Physician/ DUM 2010 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 4c in one the black the ideal. Ce Burn Aune Gleu If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 6. Sev Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔂 Maryland Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 ☐ Yes 2 🕅 No Pasadena Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number P ed other than "natural", or items 23a or event, the Medical Examiner must be permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must ha Funeral 21122 U.S.A 182 Lowes Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married ģ ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/A Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ira Helen Derie Avers 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 182 Lowes Way Pasadena, Maryland 21122 Gene A. Veillette (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State Date 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Pk. 105/26/10 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final barachnoid Pnysician/ -Da46 disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Examir attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death the detached 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed' certificate To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA hours after death.

Ineral Director: After this
d filled in by the funeral dil 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 42665 23 2010

State
Registrar

Har K

32. Registrar's Signature

2106

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Madrisur

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Items 24a, 25 per dr. 2903,05/27/2010dhb

Red, No. 1 - For State Registrar Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last Day Year Month 6.20 A M **Physician** VILLI AMS 23 2010 MAY /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1stown 'sa 05 and Imore Age (In yrs. last birthday) Funeral Year Months Days 1 **X**M 2□ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 1 XYes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20707 7303 12 Was Decedent Ever în U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical (Give kind of work done during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) rehouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ပ Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) eaf 7**0**03 -loating 20707 Laurei 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o once. Department of Baltimore 1 ■ Burial 2 ☐ Cremation 3 Removal from State Zion 5-28-10 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Name and Address of Facility aughn C. Greene Baltimore Nationa 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ESPIRATORI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of) الكريم بالمنافقة المنافقة الم attending physician for use as the burial Completed by Physician/Medical signed by the attending place as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 24 No 1 ☐ Yes 2 ☐ No 1 □Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 276 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 TYes 2 No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide e Hospital of 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier allosse 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 253 ASNERM 2835 SMITH 31. Date filed (Month, Day, Year) 22. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Sherman Ray Williams 2010 9:40 AM Medical May 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4185 Hallowing Point Road Prince Frederick Calvert 7. Age (In yrs. last birthday) Funeral Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Hours (Month, Day, Year) 04/04/193] West Virginia **Director** 232-48-6907 79 Usual Residence of Decedent 28a-f show and Mental Hygiene. I smarked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4185 Hallowing Point Road 20678 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) t. Page 1 and 2 should be filed with trment of Health and Mental Hygier rtant: If item 27 is marked other 1 njury or other traumatic event, th Health Care Researcher US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Williams Elva Evaline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Ellen Williams / Wife 4185 Hallowing Point Rd, Prince Frederick MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If its any injury or ot Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry | 05/24/2010 | Hanover, Maryland Signature of Funeral Service License 22. Name and Address of Facility ANATOMY GIFTS PUGISTRY 7593 COUNTELLEY DD. STEA HAUDU'R MS 31076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final PARKINSONASNI Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in listed average). Due to for as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death the Unknown 9 Unknown P.O. s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed? this certificate 1 Yes 2 □ No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 Tyes 2 XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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	Physicia Medic		Nathan Weaver			_			May .	21 2011	
	Examin	er	4a. Facility Name (if not institution, ga Union Memoria	al Hospita			В	altimore		4c. County of Dear	
	Funeral Director		235-50-1516	. Sex 1 XX M 2 □ F	(In yrs. last b	irthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 29	Year) Co	thplace (State or Foreign untry) Virginia
	nd how at		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation			<u>· </u>	10d. Inside City Limits
	daryla 8a-f s tified	Director	MD N/	/A		Bal	timore				1X Yes 2 ☐ No
	a or 2 be no		10e. Street and Number				10f. Zip Code		1	0g. Citizen of What Co	ountry?
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936	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important if fire 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	वि	 11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 	12. Was Decedent Education of the Armed Forces? 1 X Yes 2 1 No 1 Yes, Give Year or Dates.			Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
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and	ntal H	To Be	17. Father's Name (First, Middle, Las Nathan Weaver	'				18. Mother's Name Ruth Cl		,	
Ž	ould by mark mark		19a. Informant's Name/Relationship		City or Town, State, Zi	o Code) 21212					
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Baltimore, Maryland 21215-0036	Page 1 an nent of He ant: If iterr ıry or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	☐ Removal from State	6/1/10-	6/10/10 lem .	20c. Location - City or Dudnalk, M Owings Mi				
Balti	permit. Departr Imports any injs		21. Signature of Funeral Service Lice	L'arus		4 2	Name and Addres	ss of Facility Ch air Road	atman-l Baltin	Harris Fu more, MD	neral Home 21206
1	hysician/ Medical Examiner	g /1	23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	omplications that caused y one cause on each line. a. Due to (or as a	consequence	e of):	the mode of dyin	Pulmon		n'sease	Approximate Interval Between Onset and Death
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. Box 68760	or the hospital or Attending Prysician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal dea		Ectopic pregnand Other (specify)	Gy		23d. Date of de	olivery Day Year
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Vita	ysicie is cert direct	To Be	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/	Outpatien	t 3 🗆 DOA Oth	er: 4 Nursing Ho	ome 5 🗆 Reside	ence 6 🗆 Other (Spec	cify)
on of	ending Pradth.	Certificate:	27. Manner of Death Natural 5 Pending Accident Investigat	tion	y Year) 28b	o. Time of injury	28c. Injury work M 1 🗆		28d. Describe ho	w injury occurred	
Divisi	tal or Atters of all Directors of in by the		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine			farm, stre	et, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ıral Route Number,
	ine Hospi in 24 hou the Funer ipleted fill	Medical	(Check 2 Medical Exa	Physician: To the best of r aminer: On the basis of ex lurse Practioner: To the b	amination and	d/or invest	igation, in my opinio	on, death occurred a	t the time, date and	d place, and due to the	cause(s) and manner stated.
	<u>o</u> # 6 0		29b. Signature and title of certifier	, fall,	818	>	PAT 2	e number 438946		9d. Date signed (Mont	p, Day, Year)
_	HV			ILL MID	Uni	a) (Type, P	rint) Mem®	iel Ha	spiral	, Ballin	mone, MD
	Stat	te	31. Date filed (Month, Day, Year)	2010 32 Registra	r's Signatur	100	ELRA				

fakent known all LEROY WADDELL
Baltimore. Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 2:30 PM MAY 2010 Medical 10 4a. Facility Name (in not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OF BALTIMORE HOCPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day,

Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9 Birthplace (State or Foreign 1 **X**M 2 □ F Director Usual Residence of Decedent 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sl notified 1 XYes 2 ☐ No ö 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must be Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. ò þ 1 Never Married 2 ☐ Married 5-0036 1 ☐ Yes 2 No Specify. "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry ge 1 and 2 should be filed within 72 h nt of Health and Mental Hygiene. E If item 27 is marked other than "n or other traumatic event, the Medi (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of cemetery, crematory or other place) 6 Burial 2 🗆 Cremation 3 🗆 Removal from State Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture Fun ral Service Licens P. Name and Address JOS Eph. L. 2222 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ACUTE IGCHEMIC STROKE disease or condition resulting in death) DAYS Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Month Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION, DIABETES MELLITUS, ATRIAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of death? FIBRILLATION, CARDIOMYOPATMY, STROKE GOUTY 24a. Was an 24 hours after death. Funeral Director: After this certificate has performed ARTHRITIS, CHRONIC RENAL INSUFFICIENCY Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: |은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature 29c. License number AMIT BHISE MBBS RES-000 24 2010 MAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMIT BHISE INNAI HOCPITAL OF BAUTIMORE, MD -21215 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Margaret Wilson Physician/ Month 5/2072010 10:50a м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13726 Jarrettsville Pike Phoenix Baltimore Social Security Number 494–12–2934 **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) KS 8. Date of Birth 1 □ M 2**X** 88 Months Days Hours Min Director 8/8/1921 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Phoenix 1XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13726 Jarrettsville Pike USA 21131 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc.

white 9 1 Never Married 2 Married ☐ Yes Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Completed 3 Widowed 4 Sivorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Store Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Van ပ Gott Mable Ruth 19a. Informant's Name/Relationship (Type, Print)

Janet Beaumont / Daughter 195. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13726 Jarrettsville Pike, Phoenix MD 21131 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State Riverside Cemetery 5/28/2010 Spsingvale ME 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service LicenseeVictor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, RHEUMATIC HEART DISEASE 80 4 Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Unuenying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by PULMONARY FIBROSIS cate has been signated by page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page performed 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural injury 5 Pending work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifiei Lettifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check з 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24740 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Honds HOSPITAL MI) TRAILL BALTIMORE HOPKINS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last)
 Carolyn 2. Date of Death 3. Time of Death Wadsworth Physician/ Month 5/2472010 7:10pm M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fairfield Rehab Center Crownsville Anne Arundel Social Security Number 301–32–6364 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 F (Month, Day Year) 35 Months Days Hours 74 Director Ohio Usual Residence of Decedent show 10a. State filed within 72 hours after death with the Maryland al Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Crownsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1454 Fairfield Loop Road 21032 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 🄀 Divorced If Yes, Give Year or Dates 1 Yes 2 Who Specify: white Specify Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company Graphic Artist Be Father's Name (First, Middle, Last) Charles Preston Dray should be file th and Mental Hy 7 is mark 18. Mother's Name (First, Middle, Maiden Surname) Inez Gertrude Marvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Wadsworth permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra 425 Maplewood Avenue, Whitehall Ohio 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State OH 1 Burial 2 Cremation 3 Removal from State Washington Cemetery 5/28/2010 4 ☐ Donation 5 ☐ Other (Specify) Washington Court House Squature of Funeral Service Licensee Victor P. Charles L. Stevens Funeral Home, Inc 1501 East Fort Avenue, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Num um Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year hed should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requir within 24 hours after death.

To the Funeral Director: After this certificate has been. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Tes 2 No Other: 1 🗌 Inpatient 2 🗎 ER/Outpatient 3 🗍 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

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(Check only one)

29b. Signature and title

30. Name and address of per

3 □

who completed cause of death (Item 23a) (Type Print)

208

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Dav. Year)

Annetta Walker Patient known as

			Please Type o State 1 - State Registrar	of Maryland / I	Depa		Health and M	lental Hyg		0010	16653
	Physicia Medi		1. Decedent's Name (First, Middle, Last) Ametta Walker					2. Date of Dea Month MAY	th Da 24		3. Time of Death 22 · 40 P M
	Examir		4a. Facility Name (if not institution, give street and not Sinai Hospital of Ball	timore		4b. City, Town, o Balhim	r Location of Death are City		4c.	. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. last birt	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 0-2-1	h (23 ^{ar)}		hplace (State or Foreign intry) MD
	laryland 3a-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County MD Baltimore	10c. City, Town	n or Loc						10d. Inside City Limits 1 ☐ Yes 2 ☐ Xio
	with the Ns 23a or 28	Funeral Director	10e. Street and Number 16720 Hereford Road	1		10f. Zip Code	11		10g. Cit	tizen of What Co USA	untry?
980	e filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		Armed	s 2 L∆No live	li li	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify:	
21215-0036	nin 72 hou ne. han "natu e Medical	Completed by	15. Decedent's Education (Specify only highest grade complete Elementary/Seconday (0-12) College	d) (1-4 or 5+)	(Give I life. D	O NOT use retired)	during most of worki	ing		and of Business	•
land 21	be filed within ental Hygiene. ked other tha ic event, the h	To Be C	17. Father's Name (First, Middle, Last) Wesley Davage		ACMILI	nistrator	18. Mother's Name Martha C				ity Adminstrati
, Maryland	ge 1 and 2 should be file int of Health and Mental H t: If item 27 is marked o r or other traumatic eve	20/2	19a. Informant's Name/Relationship (Type, Print) Margaret Cook/ Daughter	19t 2	o. Mailin	ig Address (Street Sundew Ten	and Number or Rura cace, Baltim	ore, MD 2	r, City or 21209	Town, State, Zip	Code)
Baltimore,	permit. Page 1 and Department of Heal Important: If item : any injury or other once.	(20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Benation 5 ☐ Other (Specify) 21. Signature of Funeral Fervice Licensee	m State 20b. Place o cemete Druid	ry, cren Ride	sition (Name of natory or other place Cemetery . Name and Addre	ce) 6–2–	ocation - City or sville, M			
	Pnysician Medical Examiner	ər	the k	pracic and oracic and o (or as a consequence pertension	not ente	200 Liberty or the mode of dyin	Road, Rand	allstown,	MD.	21133	Approximate Interval Between Onset and Death
P.O. Box 68760	hat the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical Examine	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last C. Due 1 IF FEMALE: 23b. Was deceded pregnant 23c. If yes, or	o (or as a consequence o (or as a consequence utcome of pregnancy	of):				_	23d. Date of del	iverv
Box	the death by the atter ached for u	hysicia	in the past 12 months?	e Birth 2 Fetal deat egnant at time of death known		Other (specify)	cy			Month	Day Year
ds, P.C	w requires that i s been signed b s should be deta	by	Part II. Other significant conditions contributing to	death but not resulting	in the u	nderlying cause gi	ven in Part I.	23e. Did to		/	the cause of death?
Recor	sician: The law rec s certificate has bee lirector, page 2 sho	Completed	Coronary Artery Dise	ase				24a. Was a autop perfor	osy rmed?	prior to death?	topsy findings available completion of cause of
Vital	ysician: s certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/O	utpatier	Oth	lace of Death (Check er: 4 Nursing Ho		lence 6	5 ☐ Other (Spec	ify)
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Certificate:	1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		Time of injury arm, stre		y at k? Yes 2 🗆 No	28d. Describe h 28f. Location (S City or Tow	Street an	d Number or Rui	ral Route Number,
Ď	ne Hospital o n 24 hours af ne Funeral Di pleted filled ir	Medical C	29a. Certifier 1 Certifying Physician: To the (Check 2 Medical Examiner: On the to only one) 3 Certifying Nurse Practione	best of my knowledge, asis of examination and/o	or invest	tigation, in my opini	on, death occurred a	nd due to the cau	use(s) ar	nd manner as sta	cause(s) and manner stated
	To the within To the Complex c		29b. Signature and title of certifier M. D		(5	29c. Licens	e number ES-000- ald Bal			tte signed (Month	1, Day, Year) 24 - 2010
	Sta	te	30. Name and address of derson who completed care SANJAY MUNICEDD 31. Date filed (Month, Day, Year) 32	M Registrar's Signature	Single, F	in Hospit	ald Bal	timore			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2100 Washinaton М Coatelia May 19, 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Seasons Hospice of Baltimore 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex **Funeral** (Month, Day, Yea Country) Maryland Months Davs Hours Min. 1 M 2 F Aug 17, 1926 Director 212-22-6858 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified expone. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 No Baltimore Maryland N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21215 4827 Cordelia Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo Specify Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department Store Elementary/Seconday (0-12) College (1-4 or 5+) Waitess Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Austa Barnes James Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4825 Cordelia Avenue Baltimore, Maryland 21215 Joyce Pernal 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 05/25/10 Battimore, Maryland Arbutus Memorial Park 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. 300 Eutaw Place Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final increatic cancer Ph sician/ disease or condition **Medical** resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Unochying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 □ Probably 4 □ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 1 2 🗀 No 1 🔲 Yes Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, 4 \ Nursing Home 5 \ Residence 6 \ Other (Specify) examiner? 2 No Hospital: Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred injury 5 Pending Natural 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) To the Hospital within 24 hours To the Funeral I the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00057465 MSKAJAPOWNEM:D

State Registrar Smith

2835

istrar's Signature

Baltimore,

5. 235.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ May 13 2010 4:25 A Allen Jean Bonnie Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Carroll Copper Ridge Sykesville If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Month Day, Year 1925 1 □ M 2**X**□ F Months Hours Min. Wisconsin Director 85 397-18-3069 Usual Residence of Decedent it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, th. Me Itcal Examiner must be notified at. 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State should be filed within 72 hours after death with the Maryland Director 1 Yes 2 v No Maryland Knoxville Frederick 10f, Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral United States 21758 3326 Carlisle Drive Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced WWII 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Hospital Administrative Assistant 12 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ Ella Loomis Kenneth McNaughtan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Gaithersburg, Maryland 20878 Carrie Louise Allen/daughter 6 Relda Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ☐ Burial 2 ★Cremation 3 ☐ Removal from State Woodbine, Maryland Final Journey Crematory 5/15/2010 4 ☐ Donation 5 ☐ Other (Specify) Sign ure of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M M00957 MD 21029 Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Physician/ $\rho \rho kc$ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy has perforn death? 2 No 1 Yes certificate Yes 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ nours after death.

neral Director: After this affiled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) or Attending iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Suiciae ☐ Homicide determined within 24 hours a

To the Funeral I

completed filled Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier K100599 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRN Registrar's Signature 31. Date filed (Montilu 32 State Registrar

DHMH 17 Rev 7/2009

10-03168	
Beverly Averill	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

severly Averill		For State	ate of Maryla		artment o		l Mental	Hygiene	D N-	201	0	6656	
Physician		egistrar . Decedent's Name (First, Midd	e,Last)					2. Date of			3. Tim	e of Death	
Medical Examin		Beverly Jan Av							4, 2010	Year		12 hrs	
	4	 Facility Name (if not institution Chester River Hospita 		mber)		4b. City, Town, or L Chestertown		eath		c. County of Queen Ar			
Funeral.	5	Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Year	If Under 24	1Hrs 8 Date 6			9. Birthplace	/State or	
Director			1 M 2 X F			Months Days	-	Min	27/196	i i	Foreign Country)	MD	
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any	_	0a. State 10b. County		10c. City	, Town or Locat	ion					10d. lr	nside City Limits	
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th the Maryland 23a or 28a-f sho notified at once		3603 McGinnes F	Rd.			21651			l t	JSA			
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72 hou	Completed	Elementary/Secondary (0-12)	College (1-			ost of working life. [1.00		1000,1110,000,9		
036 ithin ne.	림	11			Home	maker				0wn	Ноте		
1 othe		7. Father's Name (First, Middle,	Lest)			18	3.Mother's Na	ame (First, Midd	lle, Maiden	Surname)	1101110		
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	e O 19	Rusty Herbert Ja. Informant's Name/Relations	Arthur Av	<u>erill</u>	Land The Int		Tiffan	y Joann	Fay	Zimme	rman		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other tranumatic event, the Medical Examiner must be notified at once	۲ ۲	<u> Trancis R. Berk</u>	Signific	ant		Address (Street						ode)	
and 2 and 2 fealth frem 2 traur	20	Prancis R. Berk Da. Method of Disposition	/Other	20b.	Place of Dispos	McGinnes ition (Name of ceme	Rd M etery,	illingt Date	on <u>N</u>	ID 216 Location - C	51 ity or Town, §	State	
nore ages l nt of F it: If i	1			in otate	crematory or oth		. _	10.10010					
Baltimore, permit. Pages 1 at Department of Her Important: If ite injury or other tr		Donation 5 Other Sp 1. Signature of Funeral Service		Ch	lesapeak 22. N	e Cremati	ton 5	/3/2010	S	teven	<u>sville</u>	, MD	
Perm Perm Dep		Juan Fellew	1		Fe1	ame and Address of lows, He Speer Ro	lfenbe 1. Che	in & Ne	wnam	Funer 2162	al Hom O	e	
Physician	132	### 130 Speer Rd. Chestertown, MD 21620 ### 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. #### Approximate I Retween Ons											
/Medical Examiner		nmediate Cause (Final disease	a. Oxyc	odone i	intoxica	tion					Detw	een Onset and Death	
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	E (□	ause. Enter Underlying Cause Disease or injury that initiated	C										
cuted und transit	, B E	vents resulting in death) Last	Due to (or as a d.	consequence o	т):								
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Division of Vital Records, tal or Attending Physician: The law require as lare redain. 1 Director: After this certificate has been side in by the funeral director, page 2 should be partification: To Be Commission.	2	Accident Invest	rigation FG 4/		Fd 11:3	t, factory, office buil		28f Locatio	n (Street a	nd Number	or Rusal Rout	e Number City	
Division o spital or Attending nours after death. neral Director: Aft filled in by the func	3 5 4	determ	not be		nd in ca		unig, oto.	or Tow Milli	n, State) 3	3603°M	cGinni	e Number, City .S KCI	
Hospi 24 hor Funct tely fi		a Cortifier	ysician: To the best	of my knowledg	ge, death occurr	ed at the time, date	and place, a				stated.		
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funcari Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the L. Maddiesal.	on on		niner: On the basis of and manner sta	examination as								(s)	
H × H 2	29	b. Signature and title of certifier			_	29c. License r	number	·	29d. [Date signed	(Month, Day	Year)	
		4)-100-				O.C.M.	E.		Apri	il 24, 2010	0		
	30	Name and address of person v				Donn Ctt D	Dalkies :	MD 04004	•				
	24	Donna M. Vincenti, MD				Penn Street, E	aitimore,	MD 21201					
Stat Registra	~	. Date filed (Month, Day, Year)	1 0 3 2010°	istrar Signatu	as de	PART							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Day **Physician** 2010 ROBERT L. **ADAMS** 09 11:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 28564 GILNOCK ROAD EASTON TALBOT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Yrs 200-32-7131 67 Director 12/08/1942 PA Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f si traumatic event, the Medical Examinar must be notified **Funeral Director** 1 ☐ Yes 2 X No MD TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28564 GILNOCK ROAD 21601 UNITED STATES death 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) MANAGER PRINTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT L. ADAMS HELEN HUBER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS KENNEDY/WIFE 28564 GILNOCK ROAD, EASTON, MD 21601 20b. Place of Disposition (Name of competery, crematory or other particles of CHESAPEAKE CREMA CENTER 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 **X** Cremation 05/11/2010 | STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P 200 SOUTH HARRISON STREET, EASTON, MD 21601 Approximate Interval Betwee Onset and Deal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown signed by the period of the details Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 s autopsy performed? Yes 2 No certificate Division of Vital 1∏Yes 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural Natural ours after death. neral Director: A y filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) within 2 To the I 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

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Tustelmans Lane, Easton, MD 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** \textbf{P}^{M} JOSEPH LEE ANDREWS 7:15 10 2010 /Medical May 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot <u>Genesis Health Care-The Pines</u> Easton f Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)

MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F Months Days Hours Min 09/10/1947 Director 218-48-5257 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evantium unat be motified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No **Funeral Director** MD TALBOT **EASTON** 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21601 6237 LANDING NECK ROAD U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Barrimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 X No Specify: Specify: Completed by 3 ☐ Widowed 4 👿 Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION HELPER 8 -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ SAMUEL LEE ANDREWS LENA DORIS TRAVERS ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6237 LANDING NECK ROAD, EASTON, MD 21601 MARYLEE BORGA/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State CHESAPEAKE CREMATION 05/13/2010 | STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 45ARS **Physician** disease or condition resulting in death) /Medical Examiner RKINISONS Se unitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting is doubt) lost. Due to (or as a consequence of Examiner law requires that the death certificate be executed and burial-tra resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe Yes 2 certificate Division of Vital 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 1 Yes 2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending Natural A 5 Pending Investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 2. To the F and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State

Registrar

30. Name and ad

31. Date filed (Month, Day, Year)

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ss of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May Day Enrique Afanador 7:45 am 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 7407 Old Sandy Spring Road Prince George's Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Columbia 1 **№** M 2 □ F Months Days Min Director 550-90-5478 84 Usual Residence of Decedent ral", or items 23a or 28a-f shor Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland | Prince George's 1 Yes 2 X No Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7407 Old Sandy Spring Road 20707 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 □ No Specify: 3 Divorced Specify Other White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Unobtainable Watchmaker Jewelru Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fernando Afanador Catalina Perez and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Ruven Afanador - Son 420 W. 25th St., #7B. New York. New York 10001 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1
Department of
Important; If it
any injury or o 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Columbia Memorial Pk. 05/13/2010 | Clarksville, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring. MD20904 23a. Part 1. Enter the disease, or shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician End-Stage Parkinson's Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown Month Day Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown should b 24b. Were autopsy findings available prior to completion of cause of death? his certificate has but director, page 2 sl 24a Was an performed? Yes 2 X No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) ဂ္ 1 🗌 Yes 2 🗶 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 X Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number

within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu

State Registra

Medical

29a. Certifier

only one 29b. Signature and title of certif

Carlos

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

32. Registrar's Sig

Covarrubias,

2

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D48290

8121 Georgia Avenue, Suite 405, Silver Spring, MD 20902

May 10. 2010

29c. License number

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year MAY 2010 a™ 20 8:36 D L BLANKENSHIP 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Kent Chester River Hospital Chestertown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 □ F Yrs 63 Virginia May 18 1947 234-76-3687 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No MD Queen Anne's Millington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 114 Pfalzgroff Rd. 21651 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Self-employed 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wayne Blankenship Mary Blankenship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Julianne Blankenship (wife) 114 Pfalzgroff Rd. Millington, MD 21651 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3X Removal from State 4 Donation 5 Dother (Specify) Lester Cemetery 5/27/10 Bartley, W.VA 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD. 21635 21. Signature of Funeral Service Lice M00510

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be neutified at any Injury or other traumatic event, the Medical Examinar must be neutified at once.

physician and s the burial-trans signed by the a d be detached f s certificate has birector, page 2 s this certific al director, After within 24 hours after death

To the Funeral Director:
completely filled in by the

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	23a. Part 1: Enter the disease, or compli shock, or heart failure. List only or	ications that caused the death. Do ne cause on each line.	not enter the r	mode of dying, such as cardiac	or respiratory	arrest,		rimate al Between and Death
	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence		C ARTER DO	SCCET	23555	7	yr5
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xamin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	n M	brittes			10	YRS
dical E	L.	CENSPHEN.		ASCULAR 1	BEAS	565	13	yrs
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		oic pregnancy (specify)		23d. Date of do Month	elivery Day	Year
y Ph	Part II. Other significant conditions con	ntributing to death but not resulting	in the underlyin	ng cause given in Part I.	23e. Did	tobacco use contribute	to the caus	e of death?
q p	HYPERCHOLES	TORUL EMINA			1 🗆	Yes 2□ No	obably	4 □ Unknown
omplete	TOBACCO	ABUSE			24a. Wa aut per 1 □ Yes	opsy prior to formed? death?	completion	lings available n of cause of
BeC	25. Was case referred to medical			26. Place of Dea	1	(-		
	examiner? 1 □ Yes 2 □ □ Po	lospital: 1 ☐ Inpatient 2 ☐ ER/0	Outpatient 3 🗌	DOA Other: 4 Nursing H	lome 5 Re	sidence 6 ☐ Other (Sp	ecify)	
ation: 1	27. Manner of Death ↑★ Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe	how injury occurred		
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, fac	etory, office	28f. Location City or To	(Street and Number or Fown, State)	Rural Route	Number,
dical (29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Exami	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	ge, death occur and/or investiga	rred at the time, date and place tion, in my opinion, death occu	e, and due to thur arred at the time	e cause(s) and manner e, date and place, and du	as stated. ue to the ca	use(s)
Me	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mor	nth, Day, Ye	ear)

State Registrar 105,

Ste 32. Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bernard King,

31. Date filed (Month, Day, Year)

C20004413 MUY

1403 Foulk Rd. Wilmington, DE. 19803

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Angelo Berti 610 M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deatl TON HEERITUI 9+ EAST E EMS a 5. Social Security Number If Under 1 Year Months Days 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 □ F Hours 6/28/1929 Director 140-24-1213 80 NJUsual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Xyes 2 🗆 No Talbot Easton 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 713 Dover Street 21601 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. δ 1 X Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify. White 3 Divorced 4 Divorced Completed Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 6 Never Worked Be Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic eventone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arturo Berti Barbara Stancher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Fraccaroli/Nephew 8979 Orchard Dr. Chestertown, MD 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bernard's Cem. 5/11/2010 Bridgewater, NJ 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
130 Speer Rd. Chestertown, MD 21620 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, ermon, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) 9 Unknown signed by t d be detach Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Winknown Completed peen 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death? autopsy Director: After this certificate I in by the funeral director, page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{\tint{\text{\tin}\text{\texi\text{\texi}\text{\text{\texitex{\text{\text{\texi}\text{\text{\texi}\text{\texi}\text{\text{\texi}\text{\texitit{\text{\text{\text{\texi}\text{\texit{\text{\texi}\text{\ 1 Yes 2 No ြု 1 Depatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State within 24 hours a Medica 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD e ld istrar's Signature State Registrar

10-03717 Calden Bumphus Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			anes					.C.M.E.			May 15, 20	J10 			
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ORIGINAL

10-03731 Sara Bishop Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ara Dioriop		1- For State	e or waryland		tificate of				Reg. No	2011	15553
Physicia	_	Registrar 1. Decedent's Name (First, Middle,L	ast)					2. Date of De	ath		3. Time of Death
Medical Examin		Sara Melissa Bi	Ishop					Month May 15,	2010	Year	0917 hrs
		4a. Facility Name (if not institution, g			1	4b. City, Town,		f Death		c. County of Dea	th
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Funeral Director					ast birthday)	If Under 1 Ye Months Da		1.00-	,	Fore	irthplace (State or ign
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D 212 should be and Menta 7 is marko	0	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (Stre		per or Rural Route Nu		City or Town, Stat	e, Zip Code)
MD d 2 should be and a 27 is summat		Maxine Larrimore	e/mother								, MD 21620
ore, tr	-	20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from Sta	1	lace of Disposi rematory or oth	ition (Name of co ner place)	emetery,	Date	20c.	Location - City o	r Town, State
Page Page nent o		4 Donation 5 Other Specific	fy:		sley Ch	ape1		5/21/10	Ro	ck Hall	, MD
Baltimore, MD 21.7 permit. Pages 1 and 2 should be Department of Health and Men Important: If item 27 is mar injury or other traumatic ever	ſ	21. Signature of Funeral Service Lice	ensee		22. N Fe	ame and Addres	ss of Facility He1fen	bein & Nev	wnam	Funera	1 Home
	4	23a. Part I Anter the dispase, or con	polications that caused	the death	Do not enter th	0 Speer	Rd. C	hestertown	n M	D 21620	Approximate Interval
Physician	-	failure/List only one cause on	each line. Atherosc1						1050, 511	ook, of ficult	Between Onset and Death
Examiner	-	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse			Tovascu	ıaı uı	sease			-
	-	Sequentially list conditions,	o	4	,.						
	۱ <u>ق</u>	if any, leading to immediate	Due to (or as a conse	quence of):						
	Ē	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of)):			-			+
760, frate be executed g physician and the burial - transit	ום		d								
be exe	Medical	X UNPENDED	$\begin{bmatrix} AMENDED \\ 23a.27. \end{bmatrix}$	perml	E. g904	6/7/10	TT				
76C ficate ficate g phys		IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcom		ancy				23	d. Date of deliver	
Sox 687 leath certific e attending I for use as the	lä	past 12 months?	1 Live birth Pregnant at t	time of dea	- H	al death 3 ner (Specify)	Ectobic (oregnancy	4	Month	Day Year
). Boy the death by the att	S	1 Yes 2 No 9 Unknov	∕n 9 Unknown			,,,					
bat the ed by letach	7	Part II. Other significant conditions	contributing to death	but not re	sulting in the u	nderlying cause	given in Part				the cause of death?
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Physical directions	٥,	1 Yes 2 No 27. Manner of Death	28a. Date of Injur		ER/Outpatient 28b. Time of In		Other ₄			ence 6 🗸 Othe	r: Scene
n of ding Ph	<u> </u>	1 Natural 5 Pending	(Month, Day,Ye	ar)	200. Time 01 III		Yes 2 1	1	now mg	ury occurred	
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Division os spital or Attending tours after death neral Director: After filled in by the fune		3 Suicide 6 Could no determin	t be	,		, ,,	3 i	or Town,			
Hospi 24 hou rely fil		29a. Certifier 1 Certifying Physi-	cian: To the best of my	knowledge	e, death occurr	ed at the time, o	late and plac	e, and due to the cau	se(s) an	nd manner as sta	ted.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directors had been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Certification: To Be Completed the Direction Medical Certification of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Experience of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Experience of the completely filled in by the funeral director of the completely filled in by the funeral director of the completely filled in by the funeral director of the completely filled in by the funeral director of the completely filled in by the funeral director of the completely filled in by the funeral director of the completely filled in by the funeral director.		one) 2 Medical Examine	er:On the basis of exam and manner stated.	ination an	d/or investigati	on, in my opinio	n, death occu	urred at the time, date	and pla	ace, and due to the	ne cause(s)
_ 2	<u>₹</u> 3	29b. Signature and title of certifier				29c. Licen				Date signed (Mo	onth, Day, Year)
2		() Autorbe	ur)			O.C	M.E.		May	y 16, 2010	
	1	30. Name and address of person who			•	01		04004	•		
5N.			stant Medical Exa			Street, Balti	more, MD	21201			
Stat Registra	~	31. Date filed (Month, Day, Year)	32. Registrar	s Signaturi	e A	A Contract of the same of the					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 2, 2010 Physician/ Margaret H. Branka 9:03A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent Chestertown Chestertown Nursing & Rehab If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F (Month, Day, 1/11/1 Hours 176-20-4234 81 Director 928 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🛚 Yes 2 🗆 No Galena MD Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21635 100 Ashwood Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married ģ 1 Yes 2 2 XNo 72 hours after Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 🕅 Widowed 4 🗌 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within it is and Mental Hygiene. Y is marked at a marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Margaret Cohen Warner Haynie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 100 Ashwood Lane, Galena, MD 21635 Elizabeth Brandt/daughter Baltimore, item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of I ō <u>∓</u> Important: If is any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/5/2010 Earleville, Maryland Paul's UMC 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and-tran resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should b Anurym 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed this certificate 1 🗌 Yes 2 🗆 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral dil 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number Day, Year) 10

Registrar

DHMH 17 Rev 7/2009

State

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30. Name and address of p

31. Date filed (Month

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son who.completed cause of death (Item 23a) (Type, Print)

strar's Signature

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment ertificate				giene Reg. No.	10	6665
			1. Decedent's Name (First, Middle, La	ist)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		James	P.	Воз	rga			May	6.	2010	12:00p ^M
	Examin		4a. Facility Name (If not institution, gir)	4b. City,		cation of Dea	ath	4c.	County of Deat	h
			12099 old S	kipton R	oad		ordo				Talbo	
	Funeral			Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. last birthday	If Under Months		Under 24 Hr Hours Mir	n. (Month, Da	y, Year)	Co	hplace (State or Foreign untry)
	Director		216-38-9234	X W 201	68 Yrs.				aug.	2,	1941	MD.
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Limits
	f sho	ō	MD. Talbo	s+	Cor	dova						1 ☐ Yes 2 ☐ No
	28e-	rect	10e. Street and Number	70		10f. Zip	Code			10g. Citi	zen of What Co	untry?
	3a or	0	12099 Old S	cipton Ro	oad	2	1625				U.S.A.	
	72 hours after death with the Maryland inclurel; or Items 23s or 28e-f show disal Exacting out be inclifted at	Funeral Director	11. Marital Status	12. Was Decedent		Was Deced	lent of Hispa	nic Origin? (Specify Yes or No erto Rican, etc.)	-	14. Race - Ame	
മ	or Item	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces 1 Syes 2 ☐ If Yes, Give	No				ino Hican, etc.)	1	Black, White	
21215-0036	ours a	δ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	Army	1 Yes 2	Z NO	Specify:			Specify: Wh	ite
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7	within lene. then	ld u	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT us	ALC: NO				_ 6	
	be filed within 72 hours after death with the Marylan ital Hygiene. ad other then "neturel; or items 23a or 28e-f show event, the Madical Exacting results notified at	ਠ	12 17. Father's Name (First, Middle, Las		Pol	ice C		Mother's No	ame (First, Middle,			rcement
and	be fi	Be					'				*	
ž	should be ind Mental imarked of umatic ev	2	James R. Borga 19a. Informant's Name/Relationship		10h Mail	ing Address	(Street and		aret Bural Route Numbe		ppa Town State	Zin Code)
Maryland	nd 2 si lith and 27 is r r treur											
ė,	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke any injury or other treumatic once.		Sharon C. Box	ga/ wile	20b. Place of Disp	osition (Nam	ne of	DCOIL	Rd. Cor	20c. Lo	cation - City or	Town, State
Baltimore,	ages int of t: If it		1 ☐ Burial 2 ②Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec.		mid Sho			tn.5-	8-10	Cam	bridge	, MD.
₹	artme orten injur		21. Signature of Funeral Service Lice					1-				·
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Вох	attenc for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 ☐ Fetal death 3	□Ectopic pro					23d. Date of del Month	Day Year
o.		Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown	it time of death 5		ecny)					- Marcon
<u>α</u>	that the died by the detached		Part II. Other significant conditions	contributing to death	but not resulting in the	underlying ca	ause given i	n Part I.	23e. Did t	obacco u	ise contribute to	the cause of death?
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Be	9 L 9	m.								rmed.	death?	completion of cause of 2 □ No
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Vita	Physicien: rthis certifica ral director, p	0 B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpat	ient 2 ☐ ER/Outpatie	ent 3 DO	Other		Home 5 XResi		6 ☐Other (Spe	cify)
of		h:T	27. Manner of Leath	28a. Date of Inj (Month, D	ury 28b. Time	of 2	8c. Injury at Work?		28d. Describe	how injur	y occurred	
<u>io</u>	Attending ir death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigate	on	.,,	М		2 □ No				
Division	r Atte er de recto	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of it	ijury - At home, farm, s	treet, factory	, office		28f. Location (City or To			ural Route Number,
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	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exa	miner: On the basis	t of my knowledge, dea of examination and/or i	th occurred anvestigation,	at the time, in my opini	date and pla- on, death oc	ce, and due to the curred at the time,	date and	and manner a: I place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and the of certifier	and manner s	tated.	290	. License n	umber		29d. Dat	te signed (Mont	h, Day, Year)
	To To		29b. Signature and the of certifier	NM	2			788	7	6	ما ا	010
	RS		on Newscard	completed assess	doath /ltom 22=1 (Time		ر ر	, - 0	•			
5	HIVA		30. Name and address of person who David H. Smi		8221 Teal		ve. S	uite	301. Ea	asto	n. Md.	21601
	Sta	ite	31. Date filed (Month, Day Year)	32. Regist	trar's Signature	4						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May 9, 2010 1715 P Genevieve Hill Cromer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Prince George's Hospital Center Cheverly If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours Min 1 □ M 2 🛛 F 79 579-38-5581 Sept. 23, 1930 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventine must be collified at once. 1 Yes 2 No Director Washington DC 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20019 United States 5121 H Street SE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? 1 ∐Yes 2 🕱 No 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No Specify: 2 Black 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government 12th Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosetta Lucas Emmett Julian Hill ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3320 2nd Road North Arlington, VA Pawnee C. Maiden/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 17, Mav 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 01ivet ature of Funeral Serve 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 20019 Approximate Interval Between Onset and Death 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode shock, heart failure. List only one cause on each line. of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-trans and that initiated events resulting in death) Last to (or as a consequence of): Box 68760. attending physician The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? Month Day Year 5 Other (specify) Ó s been signed by the should be detached 9 Unknow σ, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an certificate has page 2 autopsy perform 1 □Yes 2 No ospital or Attending Physician: The hours after death, uneral Director: After this certificate iy filled in by the funeral director, par Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 2 ER/Outpatient 3 DOA မ Dispatient 27. Maprier of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Natural 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral Hospital 29a. Certifier TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State

DHMH 17 Rev 1/2001

31. Date

(Check only one)

29b. Signature and title of certifier

and address

f person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month Day, Year)

10-03	617
Clara	Cuffie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 6 5 5 7

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21215-0036	and 2 should be filed within 72 hours after death with the Maryland (sealth and Menzal Hygiene. tem 27 is market other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	BeC	17. Father's Name (First	, Middle, Las	i)					me (First, Middle, M		
212	Menta Mark mark	70 B	19a. Informant's Name/R	Relationship (Type, Print)		19b. Mailing A	ddress (Stre	Jessie		Addison ber, City or Town, Stat	e. Zip Code)
Q	2 sho	-	Steven Edwa	ard Cuf	fie /huel	brec						arvland21212
e .	Healt Healt item		20a. Method of Disposition	on	2/2 //4/25	20b. l	Place of Dispositio	n (Name of c		Date	20c. Location - City o	
Baltimore,	ages nt of nt: If other				Removal from	State	crematory or other			/14/2010	Woodbine	Marriand
Ė	nut. P artme sortan		4 Donation 5 (21 Signature of Funeral			E TII	22 Nam	e and Addres	ss of Facility	14/2010	i Don	Maryrand
ä	permit. Pages I and 2 should be file Department of Health and Mental H. Important: If item 27 is marked of injury or other traumatic event, the		Quanta 6	RUI	Tomas	M00	957 GO11 Beve	ng Home ≥rlv L	e Cremat . Heckro	tte. P.A	ice P.O. Bo . Clarksvil	ox 784 le, MD 2102
Ph	ysician		23a Part I. Enter the dis-	ease, or com	plications that caus	ed the death.	. Do not enter the r	node of dying	g, such as cardiad	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
	/ledical aminer		Immediate Cause (Final		Hyperte	nsive	atherosc	leroti	c cardi	ovascular	disease	Death
)	ammer		or condition resulting in		Due to (or as a co							
		-	Sequentially list condition if any, leading to immedi		Due to (or as a co	needilence of	n.					
		miner	cause. Enter Underlying (Disease or injury that in	Cause		risequerice of	,,.					
-	sit a	Exar	events resulting in death		Due to (or as a co	nsequence of	f):					
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ó	are be exe hysician e burial -	Medical	X UNPENDED			27,per	ME g904	6/3/1	.0 TT			<u></u>
376	incare ig phy s the l	N/M	IF FEMALE: 23b. Was decedent pregn	nant in the	23c. If yes, out	come of pregr	nancy			nancy	23d. Date of deliver Month	y Day Y ear
9 X	attending pl	Physician/I	past 12 months?		4 Pregnant	at time of de	ath -	(Specify)				
Bo	the at	hys	1 Yes 2 No 9	Unknow	n 9 Unknowr							
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ord	as bee	ompleted				_				24a. Was a autops	sy prior to	utopsy findings available completion of cause of
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<u>ra</u> .	ertifi ctor,	Be C	25. Was case referred to examiner?	-				26.Plac	e of Death (Chec	k only one)		
5	rthis al dire	To	1 ✓ Yes 2	No			ER/Outpatient 3				Residence 6 🗸 Othe	r: Scene
٥٩	After	Ë	27. Manner of Death 1 X Natural 5		28a. Date of I (Month, Da	njury y,Year)	28b. Time of Injur		ury at Work?	28d. Describe h	ow injury occurred	
Sior	death ctor: y the	äţi	2 Accident	Pending Investigat					Yes 2 No			
ivis S	after Dire	Certification:	3 Suicide 6	Could not determine	be	Injury - At ho	ome, farm, street, fa	actory, office	building, etc.	28f. Location (S or Town, St		ural Route Number, City
	hours a		4 Homicide 29a. Certifier		10,000.97							
	To the troughpar of Arturdung Frystram. The taw requires that the ceant centucate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only		r:On the basis of e	xamination ar					e(s) and manner as stat and place, and due to th	
۽ ر	To wit	Mec	29b. Signature and title o	of certifier	and manner state	d		29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)
		7.6	anelo	> '				O.C.	M.E.	İ	May 11, 2010	
			30. Name and address of	f person who	completed cause of	f death (Item	23a)	L				
			Ana Rubio MD.		nt Medical Exa		111 Penn Stre	et, Baltim	ore, MD 2120)1		
	S	ate	31. Date filed (Morth, Pa	1 1ar 4 20	32 egis	rar's Signatu	1. bar	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 453 APRIL 29 2010 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner HESTERTOWN KENT POINT ERON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2 F Months MD 96 220 20 4031 Yrs 16, 1914 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show. 10d. Inside City Limits 10c. City, Town or Location event, the Medical Examiner trust be notified at 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21620 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: WHITE þ If Yes. Give 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATOR E DUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SILCOX ORTON ۴ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/620 19a. Informant's Name/Relationship (Type. Print) SISTER permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra CHESTERTOWN, MD 320 NECK RUAD EAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1⊠Burial 2 □ Cremation 3 Removal from State PANLS CEMETERS MAY 3,2010 CHESTERTOWN, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility MANIA.
205 GREEN HERON WM/
CHESTERIONNIMD ZIETS WILLIAMS, JA 21. Signature of Funeral Service Licensee FELLOUS HELEENSEN NEW Will 130 SPEER RUAD CHESTERN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CONGESTIVE HEART FAILHRE Physician 2 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CANDIOVASCULAR DISETTSE atherwscerunc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ ANENUA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? yes 2 No page 2 **N**No Division of Vital 1 ☐Yes After this certification funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No Medical Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? or Attending 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation To the Hospital or within 24 hours after death.

To the Funeral Director: Af 1 □Yes 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0041587

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Ye

1C

+m

Suite#5 Chostoratown Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

122 Speer
32. Registry's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paul A. Caldwell, Jr. Month 3,00 A M 2010 MA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care Potomac Potomac 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 ₹ M 2 □ F Hours Jan. 28.1918 92 Minnesota 468-05-3846 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Montgomery Potomac 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 10423 Windsor View Drive United States death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: "natural", 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Nuclear Physicist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Paul A. Caldwell, Sr. Anna Lattin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelly Urbach -wife 10423 Windsor View Drive Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H cemetery, crematory or other place, 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State Metropolitan Crematory 5/6/2010 4 ☐ Donation 5 ☐ Other (Specify) |Alexandria, Virginia Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bladder CA Physician/ disease or condition resulting in death) Medical Examiner dranced Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Uncerlying Cause (Disease or iinjury that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the attending IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🛂 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Matural 5 Pending work' To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 E Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00057458 110. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pinky 5. 31. Date filed (Month, Day, Year) 4 A Y 12 2010 6502 Kenilworth Avenue: Riverdale, MD M.D Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	laryland /		artment of H tificate of L			giene Reg. No.	. 0	16670
	Physici		Decedent's Name (First, Middle, I Nancy	June	Digr	an			2. Date of De Month	ath Day	Year	3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution, g	ive street and number)		4b. City, Town, or Cumber			4c. Count	y of Death	
I	Funeral Director		5. Social Security Number 220-28-9232 6.	Sex 7. A	ge (In yrs. last b 76	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1933	9. Birthp	lace (State or Foreign
	Maryland f show	or	10a. Stale 10b. County MD Allega	any	10c. City, Tor		cation Derland				1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	3a or 28e-	i Direct	10e. Street and Number 10 N. Uberty Street	eet Apt. 601			10f. Zip Code	21502		10g. Cilizen of	Whal Cour	try?
036	72 hours after death with the Maryland Innaturel', or tlems 23a or 28e-f show diest Examirer must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent	t Ever in U.S. ? No		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	- 14. Rad Bla Specif	ce - Americ ck, White,	etc.
2	within ene. than	ompleted	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or	5+)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired mployed	luring most of w	orking	16b. Kind of B		dustry
land	inould be filed id Mental Hygis marked other matic event, if	To Be C	17. Father's Name (First, Middle, La. Elwood Kline	st)					ame (First, Middle,		*	
	nd 2 sn alth and 27 is m r traum		19a. Informant's Name/Relationship Paul Dignan Sr.		oand 19	b. Mailin 10 N	g Address <i>(Street a</i> . Liberty St.	nd Number or F Apt. 601		er, City or Town berland	, State, Zip MI	
ш.	permit. Pages 1 a Department of Hes Importent: If item any Injury or othe		20a. Method of Disposition 1 Hurial 2 Cremation 3 4 Donation 5 Other (Special Control of Control		cemet	өгү, сгөп	sition (Name of natory or other place Paul Ceme	ery	Date 5/22/2010	20c. Location Cumb		
Dail	Departi Import any inj		21. Sign fure of Jounnal Service Lic	1				<u>ginia Aven</u>	ue: Cumbe		21502	2
	hysician /Medical		23a. Part JEMer the disease, of co shops, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Con	d the death. Do	Int	er the mode of dying	g, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
L.	physician and physician and sthe burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence							
VOO .	e attending of for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)				ate of delive onth	ny Day Year
ר יט ר	n signed build be deta	by	Part II. Other significant conditions	contributing to death I	but not resulting fault	in the un	derlying cause give	n in Part I.		obacco use con res 2 🗆 No	tribute to th	e cause of death?
C 2	ite h	Completed	<i>y</i>		-				24a. Was autop perfo 1 □ Yes	med?	prior to cor death?	osy findings available appletion of cause of 2 No
IOII OI VIIAI	After	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati	28a. Date of Inju	ent 2 ER/O ury 28b. ay Year)	utpatient Time of Injury	28c. Injury Work	at ursing	eath (Check only of Home 5 Residence 28d. Describe h	dence 6 Oth)
	Fundamental Strength	ertification:	3 Suicide 6 Could not determine	be 28e. Place of In	iju ry - Al home, f lc. <i>(Specify)</i>	arm, sire	eet, factory, office	-	28f. Location (S City or Tox		ber or Rura	l Route Number,
I control of of	within 24 hours after death	edical C	29a. Certifier (Check only one) Certifying F 2 Medical Exi	Physician: To the besi aminer: On the basis of and manner si	of examination a	e, death nd/or inv	occurred at the tim estigation, in my op	e, date and place inion, death occ	ce, and due to the curred at the time,	cause(s) and made and place,	anner as st and due to	ated. the cause(s)
-	within 2 To the complet	Me	29b. Signalure and tille of certifier	-pho-			29c. License	number 33240		29d. Dale signe	9 20	Day, Year)
	Sta Registr	te	30. Name and address of person who SUNTL GUPTA M 31. Date filed (Month, Day, Year)	o completed cause of	death (Item 23a)	(Type, F	NUE CI	umber	PLAND,	Sam	1205	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 8:00 PM MARILYN ANNE DONOVAN MAY Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner STEVENSVILLE QUEEN ANNE'S 806 PETINOT PLACE 5. Social Security Number 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🕱 F Months Hours Min. JULY 6, Ye PENNSYLVANIA 1947 62 Yrs. **Director** 194-36-8494 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 Yes 2 X No QUEEN ANNE'S STEVENSVILLE **MARYLAND** 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21666 UNITED STATES 806 PETINOT PLACE death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. I ant: If item 27 is marked other than "natural", or 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE Completed 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) 4 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CROZIER BODKIN ESTHER TWEED 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL CRAIG DONOVAN/HUSBAND 806 PETINOT PLACE, STEVENSVILLE, MARYLAND 21666 or other 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State **MAY 11** CREMATION CENTER 4 Donation 5 Other (Specify) STEVENSVILLE, MARYLAND 2010 21. Signature of Funeral Service License HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. **FELLOWS** 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 ease, or complicati e. List only one cau ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 the disease Approximate shock, or hea Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): physician and is the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending properties for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death ed by the a 9 Unknow Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by be det 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an his certificate has be director, page 2 s autopsy perform death? Yes 2 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 2 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred After Natural injury 5 Pending 1 Yes 2 No after death Director: A d in by the f Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) thin 24 hours a the Funeral D 29a. Certifier 🗫 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature a 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) Name and address

Registrar

State

31. Date filed Month, Day,

2101

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 6, 2010 7:28A_M Gary McLane Dove Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Queen Anne's Church Hill 512 Roberts Station Rd If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 🕱 M 2 🗆 F Days (Month, Day, Year, 2/25/195 220-58-7802 Director 59 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Queen Anne's MD Church Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 512 Roberts Station Rd. 21623 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16h. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) the 10 Heavy Equipment Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mildred Fisher Alfred Warren Dove l and 2 should b Health and Mea tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 Roberts Station Rd. Church Hill, MD 21623 Louise C. Dove/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 5/11/10 Hill Cemetery Church Hill, MD Church . Signature of Funeral Service License 22 Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 30 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Screent at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? \$ M, CAD, CHP Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 25. Was case referred to nedical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 4 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Matural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu death. 1 Yes 2 No 2 Accider Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 일 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 7/620 MS SFEER CITESTANTUM 2. Regis ar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 15673 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1059PM JOSEPH W. ELLER 18 0105 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rosedale Baltimore FRANKLIN SQUARE HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ F Months Days Hours Min 219-34-0961 Director 8/26/1938 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examination at the Incitival at once. 1 ☐ Yes 2√2 No Director MD Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3524 Berkley Road 21034 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Y Yes 2 1 No 1 Yes, Give 1 9 5 7 - 5 9 Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Fork Lift Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wiley Eller Ruth Sapp ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois J. Eller/Wife 3524 Berkley Road, Darlington, MD 21034 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ R 3 Removal from State Harford Mem.Gdns. 5/21/2010 Aberdeen, MD 21. Signature of Juneral Service Li 22. Name and Address of Facility C. Robert Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Prostate Cancer with bone metastasis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a present of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical attending for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐Yes 2 ☐No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t Certification: the Hospital or Attending 1 Natural 5 Pending 124 hours after death.

le Funeral Director: A pletely filled in by the fi death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Fune completely fi (Check only within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 29c. License number BINH 065094 -19-2010 NGOYES

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who

NG

DR Binh

31. Date filed (Month, Day, Year)

32. Registrar's Signature

impleted cause of death (Item 23a) (Type, Print)

ORIGINAL

9000 FRANKLIN SQUARE DR Balto md 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amedn #25,28b,e,& f per ME G904 6/1/10 TT State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 637AM Thomas Nicholas Exarhakis 2010 May 10 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Berlin Nursing Home Berlin Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 □ M 2 □ F Hours Min. Director 143-03-5338 87 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director items 23a or 28a-f s ner must be notified 1 Yes 2 X No MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32 Federal Hill 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Thomas Exarbakis Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Completed 3 Divorced 4 Divorced white Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Rusiness Industry (Give kind of work done during most of working (Specify only highest grade completed) Il Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Geico Insurance Vice President Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Nicholas Exarhakis Stella Colatos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Federal Hill, Berlin, Eve Exarhakis / wife MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Evergreen Cemetery 5/15/2010 Berlin, MD o Juneral Se vice Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the alsease, or complications that caused shock, or heart failure. List only one cause on each line. he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onse and Death Immediate Cause (Final Physician/ tractured disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner**)steopenia Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Records, P.O. Part II. **Other significant conditions** contributing to *d*eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ þ Congestive 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1d vanced autopsy performed? Yes 2 No Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** æ 26. Place of Death (Check only one) 2 No 18-36-SFlospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 Yes 2 X No 05,01,2010 unknown™ Assisted Accident Investigation at within 24 hours after death To the Funeral Director. npleted filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Home 32 Federal Hill Berlin, MD 3600 Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) DME 29b. Signature and title of certified 29c. License numb 29d. Date signed (Month, Day, Year) 05, 11, 2010 H 0070020 1)0 ·DO H5045) 5/12/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAST. Diane Ceruzzi, 9715 Healthway Dr., Berlin, MD 21811 DO 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 2010 May 09 Richard G. Eppsteiner 6:05pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomeru Bethesda 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Country) New York 1 🛛 M 2 🗆 Months Days Hours April 20 Director 130-20-6440 82 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st notified a Maruland Montgomery Kensington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 9512 Barroll Lane 20895 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Owner/Operator Women's Retail Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Eppsteiner Hattie Kahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David M. Eppsteiner - Son 3212 Powers Ford Road, SE, Marietta, Georgia 30067 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Judean Memorial Grdns: 05/12/2010 | 4 Donation 5 Other (Specify) Olney, Maryland 21. Signature of Funeral Seryice Licensed 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MEMORIEN 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Months Ph_sician/ Congestive Cardiac Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Amuloid Years Sequentially list conditions, Examiner Dué to (or as a nonsequence of; cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transi Acute Renal Failure Days that initiated events resulting in death) Last Due to (or as a consequence of by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Kidney Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law hin 24 hours after death. autopsy 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident
Suicide n 24 hours after deatn. 1 Yes Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tille 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Heller. MD 8600 Old Georgetown Road, Bethesda, Maryland 20851 31. Date filed (Month, Day, Year) /32. Registrar's Signature State 1 2 2010

DHMH 17 Rev 7/2009

Registrar

2

State Registrar 31. Date filed (Month, Day," Year)

DHMH 17 Rev 1/2001

Pike Hajerstown MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14014

32. Registra s Signature

10-03543 Anthony W. Fleto		r, Sr. S 1-For State	pe or Print i tate of Maryl		Depart		Health a				Ū	201	0	1667
Physicia Medical Exami	ın/	Registrar 1. Decedent's Name (First, Midd Anthony	_{lle,Last)} Villiam FJ	letche			Douth			2. Date of 0 Month May 7,	Da			3. Time of Death 2138 hrs
		4a. Facility Name (if not instituti Western Maryland Re	1.1			4	b. City, Town Cumberl		ation of Death	n		4c. County of Allegany	Death	
Funeral Director		5. Social Security Number 236-86-7248	6. Sex	7. Age (II	n yrs. last	birthday) Yrs.	If Under 1		Under 24Hrs Hours Min	1.			Foreig	hplace (State or n untry) WV
any		Usual Residence of Decedent 10a. State 10b. County		1100		own or Location				Mug.	21,	1953		10d. Inside City Limit
	ō		gan			Paw Paw							ı	1 X Yes 2 No
vith the Maryland s 23a or 28a-f show s enotified at once.	Director	10e. Street end Number 529 Henry Mil	ler Highw	ay			10f. Zip Cod	^{le} 434			10g. C	U.S.		try?
2 = 21	Funeral	11. Marital Status 1 Never Married 2 M	1 Yes	orces?		If Ye	s, specify Cu	ban, Me	xican, Puerto	pecify Yes or Rican, etc.)	No-	White,	etc.	can Indian, Black,
ours afte atural",	à	3 Widowed 4 Di	vorced If Yes, Give Yes or Dates: cify only highest gra		ted) 16	6a. Decedent		upation (Give kind of v		16b	Specify: b. Kind of Busi		White ndustry
.0036 within 72 h giene. her than "n t Medical E	Completed	Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle		1-4 or 5+)		auring mo	st of working Labore	er		red)	o Maide	Manufa	acti	uring
1215. I be filed ental Hy arked of vent, th	Be	William Moser	Fletcher					Le	ona Ab	e		ĺ		
AD 2: 2 should h and M 27 is m imatic c	٩	19a. Informant's Name/Relations Sandra Miller		- wif			Address (S			Rural Route N		City or Town, 25434	State,	Zip Code)
nore, hages I and nt of Health it. If item other trau		20a. Method of Disposition 1 X Burial 2 Cremation		om State	crer	ce of Disposit matory or othe Hill	ion (Name of er place)	cemeter	у,	Date 11,20	200	Paw Pa		
Baltin permit. P Departme Importan	Ì	4 Donation 5 Other S 21. Signature of Funeral Service			ошир		ime and Addr	ess of F	acility	Kimble	Fu	neral l	Tome	е
Physician /Medical Examiner	Examiner	23a. Pan I. Enter the disease, failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	on each line.	onary Ar conseque rotic Car conseque	tery Thi ence of): rdiovas ence of):	rombosis	e mode of dyi	ng, such	as cardiac o	r respiratory	arrest, s	hock, or heart		Approximate Interval Between Onset and Death
e execut	L	UNPENDED	d. AMENDED						···					
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be execut as after death. al Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - tran		IF FEMALE: (3b. Was decedent pregnant in the past 12 months?) 1 Yes 2 No 9 Uni	4 Pregn	oirth ant at time		2 Feta	l death er (Specify)	3 <u>E</u> c	etopic pregna	incy	2	3d. Date of de Month	elivery Da	ay Year
s, P.O. I	2	Part II. Other significant condit	ions contributing to	death but	t not resul	iting in the un	derlying caus	se given i	in Part I.		,			ne cause of death?
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed	25. Was case referred to medica					26 01	an of De	eath (Check o	per 1 ✓ Yes	as an copsy formed	prid dea		opsy findings available impletion of cause of
Vital hysiciam this cert	٥	examiner? 1 ✓ Yes 2 No	11	npatient	2 🗸 ER	/Outpatient		Other		g Home 5	Resid	dence 6	Other:	
ion of ttending P feath. tor: After		27. Manner of Death 1 Natural 5 Pend 2 Accident Invest		of Injury , Day,Year)	28	b. Time of Inj	· _	njury at V Yes 2		28d. Describ	e how in	njury occurred		
Division spital or Attend tours after death, neral Director:	Certification:	4 Homicide deter	d not be mined (Specify)	e of Injury	- At home	, farm, street,	factory, offic	e buildin	g, etc.	28f. Location or Town		and Number	or Rura	al Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	edical	one) 2 Medical Exam	nysician: To the bes miner:On the basis of and manner s	of examina			n, in my opin	ion, deat	h occurred a					
		29b. Signature and title of certifie	Aae	9 ol	i^	~	29c. Lice O.0	onse num C.M.E.	ber			Date signed by 8, 2010	(Mont	h, Day,Year)
		30. Name and address of person Carol Allan, MD Ass	who completed caus sistant Medical I			a) 1 Penn St	reet, Balti	more,	MD 21201	1				
Sta Registr	13.	31. Date filed (Month, Day, Year)	27 2010	gistra s S	ignature	1. 1	barke	1						
DHMH 17 Rev 1/200 OCME 2006		11411	OCME		C	RIGINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 11 2010 JOHN LIU FUGH 8:46 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🕅 M 2 🗆 F Months Hours Min, Country) 577-48-9337 **Director** 75 CHINA Usual Residence of Decedent 28a-f shov 10a, State 10h Counts filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits notified VIRGINIA ALEXANDRIA 1 ☐ Yes 2 🛣 No FAIRFAX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be ms 23a Funeral 7320 RANGE ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give ò þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced Specify: CHINESE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ U.S. ARMY LAWYER, MAJOR GENERAL permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ PHILIP CHING-PO FUGH SARAH LIU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUNE CHUNG FUGH - WIFE 7320 RANGE ROAD, ALEXANDRIA, VA 22306 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ARLINGTON NATIONAL 4 Donation 5 Other (Specify) AUG. 24, 2010 ARLINGTON. VA 22. Name and Address of Facility DEMAINE FUNERAL HOME 21. Signature of Funeral Service Licenses 520 S. WASHINGTON STREET, ALEXANDRIA, 23a. Part 1. Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) MYOCARDIAL INFARCTION Medical Due to (or as a consequence of): Examiner GALL BLADDER CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day 1 Yes 2 9 Unknown 2 No Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed I 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? certificate 1 ☐ Yes 2 🙀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛣 No Other: ၉ 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **X**Natural 5 Pending injury Accident
Suicide Investigation 1 Tes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signa re and title of certifier 29c. License number

State

Registrar

DHMH 17 Rev 7/2009

le and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist ar's Sig

JOYSON KARAKUNNEL

31. Date filed (Month, Da MAY 1 4 2

0101237665 (VA)

NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600

CENTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 05 Month **Physician** HOLTON TEMPLE FLUHARTY 2010 06 11:38 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1103 SOUTH WASHINGTON STREET TALBOT EASTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday) **Funeral** 1**X**M 2□ F Months Days Hours Yrs. 90 **Director** 02/28/1920 218-24-4392 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1X Yes 2 □ No Director EASTON MD TALBOT 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 1103 SOUTH WASHINGTON STREET 21601 UNITED STATES items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 natural", or 1 ☐ Yes 2X No Specify þ Specify: WHITE 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Item 200ce. 10 MECHANIC AUTOMOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE WILLIAM FLUHARTY, SR. FLORENCE TRAX 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. LEE FLUHARTY/SON 9765 COUNCELL ROAD, CORDOVA, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN MEMORIAL 05/13/2010 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses dress of Facility HELFENBEIN & NEWNAM FUNERAL HARRISON STREET, EASTON, MD HOME, P.A. 21601 JOHN R. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebrovasa **Physician** /Medical Examiner Sequentially list conditions, if any, leading to ininiediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a the burial-Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) o 9 Unknown Division of Vital Records, P. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 □ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death.

I Director: Aid in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital within 24 hours To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) me and addre pleted cause of death (Item 23a) (Type, Print 6 R9 31. Date filed (Month State

DHMH 17 Rev 1/2001

Registrar

3+1

29b. Signature and title of certifier

Russell Alexander MD.

31. Date filed (Month, Day Year) 2010

arid address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

. Registrar's Signature neur

DHMH 17 Rev 1/2001 OCME 2006

Registra

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 18, 2010

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		1- For State Registrar	riygiche	Reg. No	16681								
Physici Medical Exami	an/ iner	Decedent's Name (First, Middle,La	Erica	Jane G	reen				2. Date of D Month May 19,	eath Day		3. Time of Death 1000 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of 221 Locust Lane Elkton							eath		c. County of De	eath	
Funeral		Social Security Number 6. 9	Sex 7	. Age (In yrs.	last birtho		Jnder 1 Ye	ar If Under 24	Hrs. 8. Date of		M/DD/YYYY) 9.	Birthplace (State or	
Director		213-04-1836 1	Min. 05/1		Fo	reign Maryland Country)							
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or	r Location						10d. Inside City Limits	
faryland 28a-f show at once.	ō	Maryland Cecil		N	orth	East						1 Yes 2 X No	
r 28a-	Director	10e. Street and Number				10f.	Zip Code			10g. Ci	tizen of What C	ountry?	
ith the 23a o	a D	91 Belvue Road	12. Was Dece	foot Evenin II	16	12 Mas Des	2190		/ O /		Jnited S		
21215-0036 Uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	Funeral	1 X Never Married 2 Marrie	A		1.5.				(Specify Yes or lerto Rican, etc.)	No-	14. Race - An White, etc	nerican Indian, Black, :	
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'2 hour "natu	eted	Elementary/Secondary (0-12)	College (1-4					tion (Give kind b. DO NOT use		16b.	Kind of Busines	ss/Industry	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	10			W	laitre:	SS				Restau	rant	
21215-0036 buld be filed within 7 Mental Hygiene. marked other than c event, the Medica	a)	17. Father's Name (First, Middle, Las	t)						ame (First, Middle		•		
2121 ould be fill Mental I marked ic event,	To B	n Eric C. Green I lammy L. Kendrick									vn, State, Zip Code)		
MD 21 d 2 should lith and Me n 27 is ma aumatic ev	311	Tammy L. Green/N	Mother		91	Be1v	ue Roa	ad, Nor	th East,		21901		
s l an file file file file file file file file		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from		Place of I cremator	Disposition (y or other pla	Name of ce ice)	metery, M	ay 22,	20c.	Location - City	or Town, State	
그 글 글 글 그		4 Donation 5 Other Specify 21 A nature of Funeral Service Lice			Unio	n Ceme	tery	2	010		Union,	MD	
Balt permit Depart Impor injury	1	21. Strature of Fulleral Service Lice) Al .	1.0					icks Hom Street,			cals, P.A. 21921	
Physician		23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications that cau ach line.	sed the death	. Do not e	enter the mo	de of dying,	such as cardia	c or respiratory a	rrest, sh	ock, or heart	Approximate Interval Between Onset and	
/Medical Examiner		Immediate Cause (Final disease a or condition resulting in death)	Asphyxia by	<u> </u>								Death	
		Sequentially list conditions, b	Due to (or as a co	onsequence o	π).								
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	onsequence o	f):								
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executed an and al - transit	1	d UNPENDED	AMENDED										
'60, zate be physici	Med	IF FEMALE:	23c. If yes, out	come of preg	nancy					23	d. Date of deliv	ery	
Box 68760, e death certificate be the attending physic of for use as the bur	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	n t at time of de	2 [Fetal dea		Ectopic pre	gnancy		Month	Day Year	
Box 68760, e death certificate be ex the attending physician ed for use as the burial -	Physician/Medica	1 Yes 2 No 9 Unknow			eath 5	_ Other (S	ресіту)			İ			
P.O.	ক্র	Part II. Other significant conditions	contributing to d	eath but not re	esulting ir	the underly	ing cause o	iven in Part I.		_	use contribute	to the cause of death?	
Division of Vital Records, ral or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed								24a. Wa			autopsy findings available	
teco	E O									opsy ormed?	death'		
Vital Recysician: The his certificate director, page	Bec	25. Was case referred to medical examiner?						of Death (Che					
F Vil	의	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inp			atient 3	<u> </u>	Other Nur	sing Home 5		ence 6 🗸 Oth	ner: Scene	
ion of Vending Physeath.	Ē	1 Natural 5 Pending	FOUND: D	ay,Year)	FOUN	D:		yatvvolk? ′es 2. ✓ No	28d. Describe Subject wa				
ivisior or Attencafter death Director:	Certification:	2 Accident Investigati 3 Suicide 6 Could not	28e Place o	f Injury - At ho	1000 h me, farm		ory, office b	uilding, etc.			and Number or F	Rural Route Number, City	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Ser	4 Homicide determine	d (Specify) S	Single Fam					or Town, 221 Locust L	ane, E			
To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 2 Medical Examine	r: On the basis of e	xamination ar	ge, death nd/or inve	occurred at estigation, in	the time, da my opinion,	te and place, a death occurre	nd due to the cau d at the time, date	ise(s) ar and pla	nd manner as st ace, and due to	ated. the cause(s)	
To with To com	Mec	29b. Signature and title of certifier	and manner state	ed	,		9c. License					fonth, Day, Year)	
		Cellss	wi	1	7		O.C.	И.E.		May	y 20, 2010		
	ı	30. Name and address of person who	completed cause	of death (Item	23a)				-				

State 31. Date filed (Month, Day, Year) Registrar AAY 27

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

32. Regis ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month Shirley Ann Grav 11. 10:25A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5501 Brite Drive Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months 1 M 2 TxF Hours Min. (Month, Day, Year Director 579-48-8354 June Pennsylvania Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 5501 Brite Drive 20817 United States items 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married "natural", or Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) National Institute Grants Assistant of Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Meredith James Linnane Anna Vosick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James T. Gray/husband 5501 Brite Drive Bethesda, Maryland 20817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Ponation 5 Other (Specify) Final Journey Crematory 5/12/2010 Woodbine, Maryland ure of Funeral Service Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse f yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No for Month Day detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐XProbably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has autopsy performe Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 **X**No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral to 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number ျ 29d. Date signed (Month, Day, Year) MD D0063196 May 12, 2010

Registrar

1355 Piccard Drive Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Matthew McAndrew,

31. Date filed (Month, Pay,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY MAY 2010 GEORGE BRADLEY GIBSON Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HERITAGE HARBOUR HEALTH AND REHABILITATION ANNAPOLIS ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Hours AUGUST 21, Year 1927 1 ▼ M 2 □ F Months Director 82 214-28-2690 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Merical Examiner must be notified at 10c. City, Town or Location **MARYLAND** QUEEN ANNE'S STEVENSVILLE 卤 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 511 ELM STREET 21666 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, was Decedent Ever in U.S. Armed Forces? 1 **X** Yes 2 □ No If Yes, Give Year or Dates. **1945–1947** Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 XWidowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **CARPENTER** CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည LAWRENCE BRADLEY GIBSON ELIZABETH GAITHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health attem 27 i GENEVA SHERBERT/DAUGHTER 511 ELM STREET, STEVENSVILLE, MARYLAND 21666 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or oth 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemeter crematon of the class of the colors 1 Burial 2 X Cremation 3 Removal from State MAY 10 2010 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND 21. Signature of Funeral Sovice Licenses P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy page death? 1 Yes 2 No Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital: 2 No Other: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending thin 24 hours after death. the Funeral Director: After mipleted filled in by the fun 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. If a triving Nume Praction or To me best of my knowledge, death occurred at the time, deterned place, and due to the cause(s) and manner stated. 29a. Certifier (Check

9:30 PM

9. Birthplace (State or Foreign

10d. Inside City Limits 1 Yes 2 X No

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month. Day, Year)

Year

MARYLAND

WHITE

State Registrar 29b. Signature and title of certifier

31. Date filed (Mo

Na | e and address of pe son who completed cause of death (lt, m 23) (Ty ... Print)

2010

32. Registrar's Signature

DHMH 17 Rev 7/2009

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year May 10, 2010 Robert Francis Gill 11:30 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arcola Health & Rehab. Center Montgomery Silver Spring Social Security Number If Under 1 Year If Under 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 □ F Months Davs Hours oct. 24, Year 1921 173-16-8720 Director 88 Pennsylvania Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland aţ 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Maryland 1 Yes 2 No Baltimore Hunt Valley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a o I Examiner must be Funeral 13104 Beaver Dam Road 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? T Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 1943-45 "natural" Specify: White 3 Widowed 4 K Divorced Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Power Generation Metallurgist <u>Equipment</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ William Gill May Della Leiden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katy G. Browne/Daughter 900 Grove Street, #6, Evanston, IL 60201 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o ò cemetery, crematory or other place 1 🔲 Burial 2 😾 Cremation 3 🗆 Removal from State May 11, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA . Sign fur of Funeral Service Lic 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver 23a. Part 1. Enter the disease, or shock, or heart failure. List on ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Alzheimer's Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, 26. Place of Death (Check only one) Be in 24 hours after deaur. he Funeral Director: After this ce noleted filled in by the funeral dire: Hospital: Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practions to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 3 🗆 29b. Signature and title of ce 2 29c, License number 29d. Date signed (Month, Day, Year) May 11, 2010 0 D09834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 Farragut Avenue, Kensington, MD 20895 Barry Rosenbaum, MD 12 2010 State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death May 8, Physician/ 2010 Oscar Ricardo Giner 11:00 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🏻 M 2 🗆 F Days Cuba. Months Hours Min. Feb. 7, 1928 Director 266-70-4182 82 Usual Residence of Decedent 3a or 28a-f show be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 12913 Hawkshead Terrace 20904 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give 1 🗶 Yes 2 🗌 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Telecommunications Engineer of Health and Mental Hygie If item 27 is marked other in other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roque Giner Lazara Valdez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a lant: If item 27 i转 Maria E. Reed/Daughter 12913 Hawkshead Terrace, Silver Spring, MD 20904 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State ò 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) May 11, 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Inc. Spring, MD 20901 23a. Part 1. Deter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to for as a nonsequence of it my leading to time of cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No ☐ Pregnant at time of death☐ Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available After this certificate has prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 XNo Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes ၉ 2 No 1 🕱 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 🔽 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) May 11, 2010 D D69288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Yodit Neggusse, MD 31. Date filed (Month, Day, State Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

MAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Allen Richard Medical Hannas 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Western Maryland Health Systems Cumberland 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Month: Hours Jan. 20, 1937 WV Country) Director 233-58-3124 Usual Residence of Decedent 28a-f shov 10a. State traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits XX Yes 2 No Hampshire Romnev 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 375 W. Birch Lane 26757 or items 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. "natural" 3 Divorced 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Dormitory Teacher D.&B. School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Eugene Hannas Clara Orndorff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sho Department of Health ar Important: If item 27 is Kav Hannas 375 W. Birch Lane Romney, WV 26757 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/22/10 Ebenezer Cemetery Romney, W 21. Signature of Puneral Service Licens e 22. Name and Address of Facility McKee Funeral Home 115 E. Birch Lane Romney, WV 26757 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ INOPERABLE RECTAL CANCER 10NTH Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Dunito (or es a consecuence of) if any leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Yes 2 No the 9 Unknown g 🗌 Unknown ate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed this certificate 1 ☐ Yes 2 🗙 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAUI AIYER

29c. License number

D0065702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Helm Carroll Kennard 7 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Examiner 4c. County of Death 231 Massachusetts Avenue Allegany Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) WV 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Min. (Month, Day 18^{ar)} 1924 236-32-5603 Director 85 Usual Residence of Decedent 28a-f shov 10b. Count 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** MD Allegany Cumberland 1 □XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 231 Massachusetts Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Completed Specify: 3 Divorced 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) salesman Schmidt Bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed treent of Health and Mental H rtant: If item 27 is marked out jury or other traumatic even ည Morgan E. Helm Roberta V. (Laing) Helm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 231 Massachusetts Ave. Cumberland MD 21502 Mary Helm wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department of Important: If any injury or once. Restlawn Memorial Gardens 5/21/2010 MD LaVale 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Servi 22. Name an Scarpelli Full Frail Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coruna disease or condition Medical resulting in death) Due to (or as a cons of nce of) **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: မ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State, within 24 hours a Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 00033280 18,20/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE CUMPERLAND, MD

Registrar DHMH 17 Rev 7/2009

State

GUPTA

31. Date filed (Month, Day, Year)

KENT

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2010 Frances Adele Hockaday 5, 7:35 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Crofton Convalescent & Rehab. Center Crofton Anne Arundel 5. Social Security Number 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1 🗆 M 2 🔼 Days Hours 93 Director 578-26-0561 June Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Examiner must be notified 1 X Yes 2 No Crofton Maryland Anne Arundel 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2131 Davidsonville Road 21114 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Armed Forces 0. Black, White, etc þ 1 Never Married 2 Married 2 XNo Yes Yes Maryland 21215-0036 Black 1 Yes 2 No Specify: If Yes, Give Specify Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Self-Employed Cab Driver 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental marked o ည Lillian Williams Eddie Ferguson and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 3909 New Haven Court - A7 20716 Page 1 and 2 Marilyn A. Edwards/ Daughter Bowie, Maryland permit. Page 1 and 2 Department of Health Important: If Item 27 any Injury or other tr Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Lee's Crematory 1 Durial 2 Cremation 3 Removal from State 15, Clinton, Maryland 4 Donation 5 Other (Specify) 2010 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Foneral Service Inc. 4001 Benning Rd. NE Washington, DC 20019 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lin Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 🛂 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident injury work? 5 Pending 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined

State Registrar

Medical

(Check

29b. Signature and title of certifier

Name and address of person who completed

2010

1 Certifying Physician: To the pest of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Joyce Ann Higbee Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Wicomico isbur at H HOSPICE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months 3 /21 940 70 219-36-5060 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Ocean City MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 10114 Pebble Ct. 21842 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Manital Status Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Yes. Give Specify 3 Widowed 4 Divorced white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Marie Cropper Dennard L. Hudson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10114 Pebble Ct., Ocean City, MD 21842 Michael Nottingham son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/16/2010 Berlin, MD Sunset Mem. Park 22. Name and Address of Facility Burbage Funeral Home -un al Strvice Lice 21. Signatury St., Berlin, 108 William 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final LUNG Physician/ NAN T disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed as the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months? Month Day Pregnant at time of death the 9 Unknown After this certificate has been signed by a funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Watural Natural 5 Pending /2 Accident Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V 130 affunda 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6^{Day} MAY 20ÎO COLLEEN BETTY HIGDON 5:00 \mathbf{A}^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPICE CENTER OF QUEEN ANNE'S CENTREVILLE QUEEN ANNE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🕱 F DEC. 22, 1930 WEST VIRGINIA Months Hours Director 213-24-6881 79 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State with the Maryland 10c. City, Town or Location Director MARYLAND QUEEN ANNE'S **STEVENSVILLE** 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 23a o 200 TERRAPIN GROVE APT. 107 21666 UNITED STATES . Page 1 and 2 should be filed within 72 hours after death irnert of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items jury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) WAITRESS FOOD SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ CHARLES O. BOSLEY ETHEL TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD STEWART/SON 37104 SOLITUDE DRIVE, SELBYVILLE, DE 19975 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If its any injury or ot Date CHESAPEARE CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signal e o Funeral Se vice Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL 106 SHAMROCK ROAD, CHESTER, MD 21619 HOME, P.A. 23a. Part 1. Enter the disease, or complications that oxysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final METASTATIC Physician/ COLON CANCER disease or condition Medical resulting in death) Die to (or as a consequence of): Examiner Securifically list for elfors if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate I leted filled in by the funeral director, page performed ☐ Yes 2 K No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) examiner? 2 X No Hospital Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of confifier 29d. Date signed (Month, Day, Year) 1 064931 MAY, 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVIS COSGROYE 600 HORTY WOLFE STREET, BALTIMONE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Month MAY CARROLL BERNARD HIGDON 6, 1555 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours Director Yrs MARYLAND 79 DECEMBER 3,1930 <u>215–28–1045</u> Usual Residence of Decedent fshow 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Tyes 2 X No MARYLAND QUEEN ANNE'S CHESTER ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 1600 CRAB ALLEY DRIVE 21619 UNITED STATES items filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. the Medical Examiner Black, White, etc. ō δ 1 Never Married 2 X Married X Yes 2 ☐ No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" 3 Widowed 4 Divorced Specify: WHITE Completed Year or Dates. 1952-1954 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) STATE 12 SURVEYOR <u>GOVERNMENT</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည JOHN B. HIGDON ROSALIE A. CARROLL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN D. HIGDON/WIFE 1600 CRAB ALLEY DRIVE, CHESTER, MARYLAND 21619 altimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MAY Date 1 X Burial 2 Cremation 3 Removal from State MARYLAND VETERANS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 2010 HURLOCK, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facili FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 , or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one caus Immediate Cause (Final Onset and Death RRHYTHOU Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ORONAR Sequentially list conditions. il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Dus to (or as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical IPIOET Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year the Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🔲 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation within 24 hours after death

To the Funeral Director: ocmpleted filled in by the 3 ☐ Suicide 4 ☐ Homícide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10+1 od D36371 ss of person who completed cause of death (Item 23a) (Type, Print)

D. E. BAWFER MD 3169 BRAVERTON ST ZOI, EDGEWATER, MD RAYMOND 32 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 11, 2010 Alonza Copeland Hubbard 11:25 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chester River Manor Chestertown Kent Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 MD **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. 2/13/2927 220-32-0294 Director 83 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1

Yes 2 □ No MD Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5575 Boundary Ave. 21661 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan 1 ☐ Yes 2 🛱 No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Waterman Seafood Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alonza Morgan Hubbard Carrie Akers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor C. Hubbard/ Wife 5575 Boundary Ave. Rock Hall, MD 21661 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Wesley Chapel 5/16/2010 Rock Hall, MD Signature of Funeral (Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death NEUMONIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) ng physician as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ģ detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated with the cause of the cause of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of (Check only one Hame and address of person who completed cause of death (Item 23a) (Type, Print) 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 28^{Pay} 2010^{ear} Olivia Hynson 2:25P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 26760 Lynndale Court <u>Mechanicsville</u> Saint Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 K Days Hours 8/29/1931 Country) Director 78 MD 214-28-8456 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Saint Mary's <u>Mechanicsville</u> 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2 should be filed within 72 hours after death with th and Mental Hygene. Saz is marked other than "natural", or items 23a 27 is marked other than "natural", or items 24 traumatic event, the Medical Examiner must b 26760 Lynndale Ct. 20659 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Lee Hynson Minnie Dierker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William L. Hynson/Brother PO Box 318 Rock Hall, MD 21661 20a. Method of Disposition
1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 Donation 5 Other (Specify) Chesapeake Cremation! 4/29/10 Stevensville, MD 22 Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final disease or condition Priysician/ CAR DID PULLION ARY resulting in death) Medical Due to (or as a consequence of): Examiner Right Lung Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine and -transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL DNSUPPICIENCY Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed typen teresion 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, it Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 🗹 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 023889

In

State Registrar 223 High Street,

c Her fer Facon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tn.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#10c 1- State Registrar 10e,10f, 5/5/2010, MS, Kent Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Dav Year Hyland 358 A M William Edward 2010 /Medical 30 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death hester town Hospita MdKent 5. Social Security Number 7. Age (In yrs. last birthday) Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min Country Yrs. 216-40-2579 Director 68 8/10/1941 MD Usual Residence of Decedent show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f sho event, the benderal Experiment regal to notified at Rock Hall Director 1 ☑ Yes 2 ☐ No MD Kent Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ,5795 Chesapeake Villa 21661 21678 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 2 If Yes, Give Year or Dates: 60-64 Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Sales/Service Manager Printing marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Menta! H Be ပ Walter Owen Hyland Mildred Louise Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Michael S. Hyland/son 11325 Urieville Lane Worton, MD 21678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Chesapeake Cremation: 5/1/2010 Stevensville, MD 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
130 Speer Rd. Chestertown, MD 21620 21. Signature of Funeral Service Licensee toren 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 povolnemic **Physician** disease or condition resulting in death) /Medical Due to (or 1 a consequence of): Examiner wall hematoma Abdomina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed Coagulopath and Due to (or as a consequence of) physician a s the burial-Box 68760, oumadin Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day Year 5 Other (specify) P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by sig. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown sc plicemia been Myocardia Inhaction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Respirator performed certificate Acute Division of Vital 2 🗆 No 1 ∐ Yes 2 12 1√No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐Yes 2 ☐ No investigation 2 Accident after death Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 0006945 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) kalakorthy 100 Brown Street, Chestertown, MD-Samantha 31. Date filed (Month, Day, Year) 32. Registra's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY 7 AGNES FENNELL HEALY 2010 3:46 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours 577-20-8952 89 1921 Washington DC Jan. 18, Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 XYes 2 No Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A.. 6200 Oregon Ave N.W. Apt. 20015 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3₺ Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aubrey B. Fennell Catharine Moormann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Babe King Daughter 3816 Jenifer ST N.W. Washington D.C. 20015 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 5-13-2010 Falls Church, VA 4 Donation 5 Dother (Specify) National_Crematory 22. Name and Address of Facility Joseph Gawler's Sons 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):

Physician /Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

or items 23a or 28a-f show Examiner nust be notified at

"natural",

permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, Its Medical once.

Director

Funeral

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Completed

Be ပ DC

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

and burial-tran attending physician for use as the buria ned by the a page 2 should peen has 24 hours after death.

Funeral Director: After this certificetely filled in by the funeral director.

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Be Completed Certification: To

Medical

that initiated events resulting in death) Last	c					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year				
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown				
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)				
1 Yes 2 XNo	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	e 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 Certifying Ph	/sician: To the best of my knowledge, death occurred at the time, date and place, a	nd due to the cause(s) and manner as stated.				

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

0101246547 (VA)

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

J. ZWETTLER

LT MC US

State

Registrar

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	Examir	er	4a. Facility Name (if not institution, give		unty of Death									
~~	Funeral		Suburban Hospita 5. Social Security Number 6. Se		rs. last birthda	Bethesd	a If Under 24 Hrs.	8. Date of Bir		gomery	place (State or Foreign			
	Director			□ M 2 X F 96	Yrs	Months Days	Hours Min.	117217	1913	Penn	isylvania			
	and show	5	10a. State 10b. County	10c	. City, Town or	Location				1	10d. Inside City Limits			
	Maryla 28a-f otifiec	Funeral Director	DC		1 🗓 Yes 2 □ No									
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	th wit ms 23 must	iner	1010 East Capito			20003				d Stat				
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental lygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 🌠 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates.	1 U.S.	 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2¾☐ No 	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, cify: Whit	etc			
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lary	should and N is ma		19a. Informant's Name/Relationship (Ty	19b. Ma	ailing Address (Street	and Number or Rura	al Route Numbe	r, City or Tow	or Town, State, Zip Code)					
e,	and 2: Health em 27 ther tr		Fred T. Jaffin Jr			Rosemary					_			
Baltimore, I	t. Page 1 tment of I trant: If it.	- 3	20a. Method of Disposition 1 V Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Odd Fellows Cemetery 5/15/2929 21. Signature of Equation 2 Sons Inc.											
Banda Banda	permi Depar Impor any ir once.	17	21. Signature of Funeral Service License	luc/		22. Name and Addres								
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death														
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			20 Nama and add	ress of person who	completed cause of	death (Item)	23a) (Tuno 5	Print)	-	-///			'///	<i>U</i>			
				ess or person who d .Kaufmann			Nint	h Stre	eet i	Frederic	k, MD 2	21701					
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DHMH 16 Rev 6/95

State Registrar

with the Maryland

death

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick Delboy, M.D., 6602

000511

Churchville Road, Suite 200, Chestertown, MD 21620

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar Regis

ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ THELMA ELIZABETH JOHNSON Month MAY Medical 2010 19:49P M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days 1 M 2 XF Months Hours Min. 08/16/1928 Director 212-24-3885 Usual Residence of Deceden or 28a-f shov filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. d other than "natural", or items 23a or 28a-f show Examiner must be notified at 10a, State 10h Count 10c. City, Town or Location Director 10d. Inside City Limits MONTGOMERY MD CLARKSBURG 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 15219 COMUS ROAD 20871 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force 0 ģ 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No "natural", Specify Completed 3 Divorced Specify: WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygien HOUSEWIFE DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev 2 CORA RHINEHART JOHN SHIPLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARLTON JOHNSON / SPOUSE 15219 COMUS RD., CLARKSBURG, MD 20871 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CLARKSBURG UNITED 05/14/2010 CLARKSBURG, MD 4 Donation 5 Other (Specify) 21. Signature of Furieral S 22. Name and Address of Facility HILTON FUNERAL HOME BARNESVILLE, MD 20838 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DOUS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death Month Day signed by the a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown page 2 should Atrial Elbrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform After this certificate 2 🗌 No Yes 2 the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital 1 Yes Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 5 Pending injury 2 🗌 No Accident Suicide Investigation Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who

31. Date filed (Month,

Dugamla

Fisher Ave

Poolesville

MD

leted cause of death (Item 23a) (Type, Print)

Do

32. Regierrar's Signature

EMBERAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 20 2010 **Physician** rnest /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Counte Ridge zykosville 5. Social Security Number 8. Date of Birth (Month, Day, Feb 15, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Hours Days **Funeral** 1937 1**X**M 2□F Yrs. Indiana 304-36-0214 73 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Geneva Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. New York 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Karyes 2 □ No Ontario Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number U.S.A. 14456 593 South Main Street 14. Race - American Indian, Black, White, etc. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White 1 Never Married 2X Married Specify: 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) the Medical College (1-4or 5+) Elementary/Secondary (0-12) Education College Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eberhart Be Magdalene Rex Keen William Isaac is marked 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 593 S Main Street, Geneva, New York 14456 19a. Informant's Name/Relationship (Type. Print)
Mrs Teresa L. Amott, Wife item 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of I
Important: if its
any injury or of
once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Smithsburg Crematory May 23,2010 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ord P.A. Funeral Home 21. Signature of Funeral Service Licensee 106 E Church Street, Frederick, Maryland 21701 M00706 Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stag Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the signed by the attending p 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? page Yes 2 No certificate Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Be Other: 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 1 🔲 Inpatient 1 Yes 2 No Certification: To this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury unerai 27. Manner of Death (Month, Day Year) After Injury To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after death To the Funeral Director: completely filled in by the f 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical x Certifying Mursed Practioner 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar COPPER RIDGE, TID Object Rd, SYKESVILLE, MARYLAND 21784

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

DANK CRNP.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20ĬV MAY 1^{D2y} DORIS E. KNOX 1:35 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CORSICA HILLS NURSING HOME CENTREVILLE QUEEN ANNE'S Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Hours Min. FEB. 28, 1927 MARYLAND Director 199-22-5900 83 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MARYLAND QUEEN ANNE'S CENTREVILLE 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 ARMSTRONG STREET 21617 UNITED STATES Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: WHITE Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ VINCENT T. WOOLFORD MILDRED BAMBARY traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH GILLEY/DAUGHTER 102 ARMSTRONG ST., CENTREVILLE, MD 21617 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MAY Date 5 permit. Page 1
Department of
Important: If is
any injury or conce. Burial 2 ☐ Cremation 3 ☐ Removal from State CHESTERFIELD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 2010 CENTREVILLE, MD Signature of Fun Service Licens FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 408 SOUTH LIBERTY ST., CENTREVILLE, MD 21617 Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATHEROSCIEROSI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.

Physician Physician and Procedure After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last by Physician/Medical MENTIA Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ▼Unknown Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? 1 Yes 2 No Division of Vital Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Tyes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? 1 Tes 2 No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the land within 2 To the land complet 3 Decertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5-13-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 205 ARMSTRONO AVE CENTREVILLE MD 21617

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month May Physician/ Kellas anaelo 45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Centa Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 M M 2 🗆 Min 673071944 65 MD Director 214-42-9954 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Examiner must be notified at Director MD 1 X Yes 2 No Chestertown Kent 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 101 Morgnec Rd. Apt. E204 21620 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. and Mental Hygiene. Completed by 1 Never Married 2 X Married 1X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specify: 3 Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Production Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George E. Kellas, Sr. Katherine Batchelor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Bonita G. Kellas/wife Morgnec Rd. Apt. E204, Chestertown, MD 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/8/2010 Rock Hall, MD Wesley Chapel 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
130 Speer Rd. Chestertown, MD 21620 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final Muclardia Physician, Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence of Exami The law requires that the death certificate be executed and tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Pregnant at time of death signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a, Was an page 2 s autopsy performed Yes 2 No prior to completion of cause of death? has 1 ☐ Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No 1 Ynpatient 2 🗆 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of İnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 03,2010 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) reene Street Baltimore, MD ZIZI State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20Î0 Edmund Pennington Lusby, Sr. May 5:00A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11840 Augustine Herman Hwy Kennedyville Kent 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min 11/10/1924 Director 85 218-16-8617 M Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Kent Kennedyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11840 Augustine Herman Hwy 21645 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. <u>۾</u> 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Agriculture <u>Farmer/Merchant</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arthur M. Lusby, Sr. Mary T. Sutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harriett A. Lusby/Wife 11840 Augustine Herman Hwy, Kennedyville, MD 21645 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place, X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Shrewsbury Parish 5/11/10 Kennedyville, MD . Signature of Funeral Service Licensee ²², Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line 1. Approximate shock, or heart failure. List only Immediate Cause (Final Physician/ disease or condition 41 a Medical resulting in death) **Examiner** Û Sequentially list conditions sequence of) if tany, leading to immediate cause. Enter Underlying Examin and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year as been signed by the 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Other significant donditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy perform 2 No Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1 🗌 Yes Other: မ 5 Residence 6 Other (Specify) this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) Manner of De th Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural
Accident 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director; Afte completed filled in by the fun 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be ☐ Sulciuc
☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioger: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date sig 0 e and address of person who use of death (Item 23a) (Type, Print) 31. Date filed (Nonth, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Year 7:35A. M Physician/ Harold A. Lundquist Marth Medical City, Town, or Location of Dea Silver Spring County of Death
Montgomery 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 x M 2 □ Marthay, 287, 1919 Massachusetts 91 010-07-8870 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Montgomery Silver Spring 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20904 Funeral 3118 Gracefield Road, #CC205 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: 3 XWidowed 4 ☐ Divorced Year or Dates er than "natura the Medical E 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha M.I.T. Project Tech traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hilda M. Lagerstrom John Lundquist .. Page 1 and 2 should tment of Health and N tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Blase -daughter 9184 Windflower Drive Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of h Important: If ite 1 Burial 2 X Cremation 3 Removal from State 5 Metropolitan Crematory 5/10/2010 Alexandria, Virginia injury 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death one hour Immediate Cause (Final Physician. Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a nonsequence of the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ò Month Pregnant at time of death 5 Other (specify) bed 1 1 ☐ Yes 2 L 9 ☐ Unknown q | Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 1 24 hours after death. page 2 s has autonsy performed?

1 Yes 2 XNo 1 ☐ Yes 2 X No certificate 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA this 27. Mapper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Naturai 5 Pending injury work? 1 ☐ Yes 2 ☐ No n 24 hours after death. Ie Funeral Director; Aff bleted filled in by the fui ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my inowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D24093 May 9, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Parkhurst, 3110 Gracefield Road Silver Spring, Maryland 20904 M.D. 31. Date filed (Month, Day, 2 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per phys. 6906 8711/10 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Purnell Lawrence Moore MO5/08/2/010 Year 2:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Corsica Hills Centerville Oueen Annes 5. Social Security Number Funeral 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours Min 0470471908 102 Director 116-26-9032 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2X No MD Kent Chestertown 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 8656 Georgetown Rd 21620 USA items death) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ō 2 1 Never Married 2 Married be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced Specify: Black Completed other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping Unknown Domestic Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Moore Edith Moore permit. Page 1 and 2 should be Dej artment of Health and Men Important: If item 27 is marke any injury or other traumatic on e. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Grinnell (niece-inlaw) 8656 Georgetown Rd. Chestertown. MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 05/15/2010 Chestertown, MD 4 Donation 5 Other (Specify) Asbury UMC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith FH 855 High St Chestertown, M ammie 23a. art 1. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) JUESTIVE HEART Medical to (or as a consequence of): Examiner HYPERTENSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year by the 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 12 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy performed? death? this certificate 2 🗌 No 1 Yes Yes 2 X No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospita ျှ 1 🗌 Yes 2. No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 🗆 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I only one) 3 4 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5/10/10 R163758 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP BENL 205A ARMSTRONG AVE CENTREVILLE MO 21617 31. Date filed (Month, Day State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Patrick O'Conno	r	State of Maryland / Department of Health and Mental Hygiene 2010 670 1- For State Registrar Reg. No.										
Physici Medical Exami		1. Decedent's Name (First, Mid		'Conno	or			2. Date of Dea Month May 22, 2	ath Dav Year	3. Time of Death 1440 hrs		
		4a. Facility Name (if not institut 616 Industrial Blvd	ocation of Dea		4c. County of Allegany	Death						
Funeral Director		5. Social Security Number 218-68-4867	6. Sex 7	. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24H Hours M		rth(MM/DD/YYYY) 7/1967	9. Birthplace (State or Foreign Country) Marylan		
d now any		Usual Residence of Decedent 10a. State 10b. County MD A11e	egany		Town or Locati					10d. Inside City Limits 1 X Yes 2 No		
the Maryland i or 28a-f show	Director	10e. Street and Number 10f. Zip Code 21502							U.S.A.			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumante event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 1 3 Widowed 4 D	If Y∈	s Decedent of Hispa es, specify Cuban, I	Mexican, Puer							
36 nin 72 hours af ihan "natural dical Examin	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			16a. Decedent	's Usual Occupationst of working life. D	n (Give kind o		16b. Kind of Bus	iness/Industry		
Baltimore, MD 21215-0036 ocrnit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than nijury or other traumatic event, the Medica	B	17. Father's Name (First, Middle William O'(Connor			18 E	Cula J	eannett	Maiden Surname) te Ward			
MD 2. d 2 should th and M n 27 is ma	의	19a. Informant's Name/Relation John O'Conno			19608	Address (Street a	al Hw	y. Fros	stburg,	MD 21532		
imore, Pages I an ment of Hea lant: If ite		20a. Method of Disposition 1 Burial 2 X Crematic 4 Donation 5 Other S	Specify:	n State	crematory or oth 1 ${ m mber}1a$	nd Crem	ıat∳ry	/23/10	Cumber:	City or Town, State Land , Mary Lan		
Balt permit. Depart Import injury		21. Signature of Funeral Service	Teachy		57	ame and Address o	Ave.	Frostbu	irg, MD	21532		
Physician /Macical Examiner		23a. Part I. Enter the disease, of failure. List only one cause Immediate Cause (Final diseas	on each line.			e mode of dying, su 1 intoxi		or respiratory arre	est, shock, or hear	t Approximate Interval Between Onset and Death		
and the second		or condition resulting in death) Sequentially list conditions,	Due to (or as a co									
ed 1sit	Examine	Due to (or as a consequence of): Course Entire Underlying Course (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): AMENDED 23a, 27, 28-f, per ME G904 6/15/10 TT										
60, te be executed ysician and burial - transit	Φ⊩											
Box 6876(e death certificate the attending physical for use as the b		23d. Date of delive past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 23d. Date of delive Month 4 Pregnant at time of death 5 Other (Specify) 9 Unknown										
P.O. E res that the d signed by the be detached	ত্র	ute to the cause of death? Probably 4 Unknown										
of Vital Records, P.O. in Physician: The law requires that the there this certificate has been signed by meral director, page 2 should be deach	Completed							24a. Was a autope perfor	sy pri m <u>ed</u> ? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No		
f Vital Re Physician: The er this certificate ral director, page	e Be L	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital:		ER/Outpatient	3 DOA Ot		ng Home 5 1	Residence 6			
Sion ottendii death. ctor: A	Certification:	1 Natural 5 Pen 2 X Accident Inve 3 Suicide 6 Cou	ding stigation Id not be (Month, Diagram) Fd 5/2 28e. Place of	ay,Year) 22/10 of Injury - At ho	Fd 1436 ome, farm, street	1 ¬ v.	2 X No	and alc	ingeste ohol Breet and Number	d methadone or Rural Route Number, City dustrial BLVd		
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical Cer	29a. Certifier 1 Certifying P	hysician: To the best o	examination ar	ge, death occurre			Cumberl d due to the cause	and, MD e(s) end manner a	s stated.		
To To con	Me	29b. Signature and title of certifi	and manner state	1 D		29c. License n			29d. Date signed May 23, 201	(Month, Day, Year)		
		30. Name and address of persor Russell Alexander MI	D. Assistant Med	dical Exam	niner 111 F	Penn Street, B	altimore, M	ID 21201				
Sta Regist		31. Date filed (Month, Day, Year)		strar's Signatu	1. par	de l						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LOUISE NELLIE PADGETT 2010 av /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Plata Center a 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 2—23—1926 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1□ M 2√ F Months Days Hours Min MD ountry) 213-22-1887 84 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f shamy Injury or other traumatic event, the Medical Evantra must be notified once. CHARLES LA PLATA MD. Director 1. Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1 MAGNOLIA DRIVE 20646 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married adgett, LOUISC Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 □X0 Specify. Specif WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SEARS & ROEBUCK CO. 12th ACCOUNTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUIS SUITE ANNA ADELE BUCKLER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA EMELIO-DAUGHTER 7775 CRESCENT RUN CT. LA PLATA, MD. 20646 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD • VETS • CEMETERY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6-2-2010 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License M00479 Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications () caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VORSIL disease or condition resulting in death) /Medical ue o (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examine death certificate be executed burial-transit Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: f yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown is certificate has been s director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F after death. I Director: After After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Hospital 29a, Certifier 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29c. License number use of death (Item 23a) (Type, Print) 30. Name and address of person who completed ca 31. Date filed (Month, Day, 32. Registrar's State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ May 20^{y} 2010 1956 Рм John William Perovich Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ceci₁ E1kton Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Country) Maryland **Funeral** DEC 16. 1927 Days Hours Min. 1 X M 2 □ F Director 215-42-0937 82 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 ☐ Yes 2 🛣 No E1kton Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral United States 21921 130 Wayside Drive 12. Was Decedent Ever in U.S.
Armed Forces? World

1 X Yes 2 No
If Yes, Give War II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Divorced 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Agriculture Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mabel V. Foreaker Joseph Perovich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 130 Wayside Drive, Elkton, MD Linda A. Perovich/Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition North East Methodist 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) North East. 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Medical Examiner Due to (or as a consequence of): Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown a I I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has funeral director, page 2 performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🔲 Yes 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 은 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate; 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by Homicide determined 24 hours Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the within To the 29d. Date signed (Month, Day, Year) 29c. License number Man 21,2010 00059223 Madarang, 30. Name and address of person who completed cause of coath (Item 23a) (Type, Print) Melchor E. NORTH STREET ELKTON 21 MD 31. Date filed (Month, Day, Year) 32. Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#20b/26 perFH 6904 6/7/2010 ws State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary C. Parker May 10. 2ี่ซึ่าด Medical 0516 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City Town or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Funeral Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 (Month, Day, Months Days Hours Min. Director 251-56-8582 1933 South Carolina 76 Nov. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Funeral Director 10d. Inside City Limits Examiner must be notified 1 X Yes 2 ☐ No Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1605 Gould Drive 20747 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ♣ No
If Yes, Give 9 Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: African American "natural" Completed 3 X Widowed 4 Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) 12th College (1-4 or 5+) Bindery Worker Government other traumatic event, Be 17. Father's Name (First, Middle, Last) Department of Health and Mental H Important: If Item 27 is marked any injury or att 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Chapman Ether Boseman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn J. Johnson/ Daughter 182 Daimler Drive Capitol Heights, Md. 20743 20a. Method of Disposition 20b. Place of Disposition (Name of ibertargiery, crematory or other plan New Hope Baptist 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State Hone Path, South Carolina 4 ☐ Donation 5 ☐ Other (Specify) 2010 Church Cemetery 21. Signature of Funer Servi 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, on heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed ttending physician and or use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequen Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death in the past 12 months? 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month signed by the 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsv perforn certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner?

1 \sum Yes 2 \sum No funeral director, Be 26. Place of Death (Check only one) Other: 2 ည 2 ER/Outpatient 3 DOA 1 npatient 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending (Month, Day, Year) within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check the only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUE, STE 340, TAKINA PARK, THD 20912 KARIM, 7610 CARRELL 31. Date filed (Month, Day, Year) **MAY 1 4 2010** 32. Registrar's Signatu State Registrar

the Hospital or Attending Physician: hin 24 hours after death. Funeral within 24 To the

Homicide

29b. Signature and title of certifier

Medical

Assistant Medical Examiner Russell Alexander MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 20, 2010

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies, Are legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1.30 AM 2011 Medical 4a. Facility Name (if not institution give street and number **Examiner** City, Town, or Location of Death 4c. County of Death 3 00 esterto ueen e Hones If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 **X**M 2 □ F Months Days Hours Min. (Month, Day, 218-28-0072 Director Yrs. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 40025 ntre Vi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 118 A 2161 an 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 **N**o Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Nidowed 4 Divorced Completed 19CK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) nul Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ OUIS 9115 4 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 6 MI Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State pemetery, crematory or other place)

ester field 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Þ High hestertown/10 Print 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ Y10 1914 10A/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): executed attending physician and for use as the bunal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Yes 2 No the 9 Unknown signed by Part II. **Other significant conditions** contributin<mark>g</mark> to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director. After this certificate hombieted filled in by the funeral director, page 1 🗌 Yes 2 XN BB 25. Was case referred to medical 26. Place of Death (Check only one) daughter's examiner? Other: 1 🗌 Yes 5X Residence 6 Kl Other (Specify) residence 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of De th 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 🗌 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature d title of 29d. Date signed (Month, Day, Year) 8 cause of death (Item 23a) (Type, Print) MS 9 0 R m 31. Date filed (Mdn

State Registrar

strar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 2010 3:58 a M Harriett Elizabeth Rowley 06 /Medical May 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cambridge Dorchester Mallard Bay Nursing Home 5. Social Security Number 1 4 1 – 2 2 – 7 5 7 1 8. Date of Birth (Month, Day, Year) 06/28/1931 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 21 F Months Days Hours 78 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location show 10d. Inside City Limits ral", or items 23a or 28a-f shov Examir or must be redified at Director 1 Tx Yes 2 □ No MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 577 Greenwood Ave. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23;
ury or other traumatic event, Inc Maxical Examir or must by Funeral USA 21613 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: 3€ Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Dorchester County Elementary/Secondary (0-12) College (1-4or 5+) Teacher Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B 2 Leroy Blacknall Harriett Kane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Deborah Nicholson/Daughter 3052 Belpre Road Apt. 202, Silver Springs, MD 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/12/10 Dover, DE. 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility Bennie Smith Funeral Home signatu Funeral Service Licenses 524 Race St., Cambridge, MD. 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) End Sta /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Due to (or as a consequence of): burial-Box 68760 attending physician certificate be Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live birth 2 Fetal death 5 3 Ectopic pregnancy in the past 12 months? Day 4 ☐ Pregnant at time of death Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.O. the þ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s 24a, Was an Physician: The certificate Division of Vital 1 ☐Yes 2 ☐NO 1 ☐ Yes 2 1110 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Inversing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner Death e Hospital or Attending Pi 24 hours after death, e Funeral Director: After the letely filled in by the funeral 28b. Time of After 1 Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 a atural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the I within 2 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) MAY 12 2010

Jan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THANWY 2. Registrar's Signature

BYRN

29d. Date signed (Month, Day, Year)

5-11-2010

ST CAMBRIDGE MD 216/3

7924

RAMROOP, DONNA MARIE

		Plea	ase Type or							-		-	ole.		
		For State Registrar	State	oi Maryiai	Naryland / Department of Health and Me Certificate of Death						Nental Hygiene				
Physicia Medic		Decedent's Name (First, Middle	гоор							2. Date of Death Month Day Year May 08, 2010					
Examin		4a. Facility Name (If not institution Holy Cro			Si	Location of	Spri				omery				
Funeral Director		5. Social Security Number 212-06-9354 Usual Residence of Decedent	7. Age (In yrs. 4		If Under Months	Days	If Under Hours	24 Hrs. Min.					place (State or Foreign htry) Guyana		
Maryland 28a-f shov otified at	Director	10a. State 10b. County	tgomery	10c. Ci	ity, Town or Loc	, Town or Location Silver Spring				ì				10d. Inside City Limits 1 ☐ Yes 2 🖾 No	
h with the ns 23a or 3 nust be ne	Funeral Di	10e. Street and Number 10508 Edgewood	od Avenue			10f. Zip	2	0901				itizen of Wh	uat Cou		
336 s after deat al", or iten examiner r	ρ	11. Marital Status 1 12 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	edent Ever in U. prces? 2 🗓 No /e	4	Was Deced f Yes, spec I ☐ Yes				ecify Yes or No- Rican, etc.) 14. Race - Am Black, Wh						
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Deceder	nt's Education est grade completed))	life. Do	kind of wor O NOT use	rk done d retired)	uring most		ing	an:	(ind of Busi	ness In	dustry	
Maryland 21215 2 should be filed within 72 h and Mental Hygiene, 17 17 is marked other than "I traumatic event, the Med	To Be Co	17. Father's Name (First, Middle, L		<u> </u>		Techn	ical			e (First, Middle	, Maiden	Surname)	. '		
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If man 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations! Neville Ramro		19b. Mailing Address (Street and Number or						Voreen Lochan Gural Route Number, City or Town, State, Zip Code) e, Silver Spring, Maryland					
Baltimore, M permit. Page 1 and 2 s Department of Health i Important: If item 27 any injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 4 Denation 5 Other (S	3 Removal from	20b.	Place of Dispos cemetery, crem	sition (Nan natory or o	ne of ther place	e)	1	Date	20c. L	ocation - C	ity or To		
Balt permit Depart Import any inj once.	(5)	21. Signature of Funeful Service L	Verila	M0124	111	800 N	vew t	lamps	<u>hire</u>	Ave.,	Silv	Fune ver S _i	ral oriv	Home, Inc. 1g. MD 20904	
Physician/Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on ea	idiones (or as a conseq				, such as	cardiac c	or respiratory a	rrest,			Approximate Interval Between Onset and Death	
Examiner	iner	Focal Severe Atherosclerosis									-				
ia e	al Examiner														
ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate be ar death. ector: After this certificate has been signed by the attending physicii by the funeral director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	ancy al death 3 C death 5 C	Ectopic p		′			23d. Date of d Month			ery Day Year			
ords, P.O. Be requires that the de been signed by the should be detached	23e. Did tobacco use contribute to the														
Division of Vital Records, tal or Attending Physician: The law requires rs after clearth. In Director: After this certificate has been signed in by the funeral director, page 2 should be a fine to the funeral director.	Completed											prid dea	or to co ath?	psy findings available impletion of cause of	
Vital Reysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?					26. Pla	ce of Deat	h (Check			<u> </u>			
Physic Physic this co	유	1 Yes 2 No		Inpatient 2		t 3 🗆 DC	Othe	r: 4 🗌 Nu	rsing Ho	me 5 🗆 Resi	idence 6	Other (Specify)	
tending Pater tor: After the funera	Certificate:	27. Manner of Death 1 Natural 5 □ Pendin 2 □ Accident Investig 3 □ Suicide 6 □ Could	gation	th, Day, Year)	28b. Time of injury	М			No	28d. Describe					
<u> </u>		4 ☐ Homicide determ 29a. Certifier 1 🕱 Certifying	Physician: To the b	of Injury - At he	y) 			data and r		City or To	wn, State)		Route Number,	
the Hos thin 24 h the Fun	Medical	(Check 2 Medical E only one) 3 Certifying	xaminer: On the bas Nurse Practioner:	sis of examinatio	n and/or investi	igation, in r leath occur	ny opinion red at the	n, death oo time, date	curred at	the time, date	and place ne cause(s	e, and due to s) and mann	the caler as st	use(s) and manner stated. ated.	
T S S S S S S		29b. Signature and title of certifier	Mym	CM		29c.	. License	number 05434	47			te signed (# May 1			
7		30. Name and address of person w	MD. 1500	se of death (Item Fores:	n 23a) (Type, Pi t Glen	rint) Road.	. si	ever.	Spri	ing. Ma	rylai	nd 20	910		
State Registra	_	Neeraj Chopra, 31. Date filed (Month, Day, Year) MAY 12	2010 J. R.	egistrar's Signa	ture da	del.			,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 20ÎT 22 Eleanor Isabell Lucas Smith 9:45 Αм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth May 23, 1924 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 🛚 F Min. Days Hours Washington, DC Director 578-20-7843 85 Yrs. Usual Residence of Deceder 28a-f shov 10a. State Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Montgomery Clarksburg ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12405 Needle Drive 20871 United States items 2 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò <u>\$</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", 3X Widowed 4 □ Divorced Specify: White Completed event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown traumatic Mary Maude Lucas I and 2 should be Health and Me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Charles B. Smith / Son 12405 Needle Drive, Clarksburg, Maryland 20871 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory May 23,2010 Smithsburg, Maryland 21. Signature of Funeral Service Licen Keeney & Basford PA Funeral Home 106 E. Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementia with Failure to thrive Physician/ 415 disease or condition Medical resulting in death) Examiner 415 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Kulmonary Discase or Attending Physician; The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events and resulting in death) Last attending physician Physician/Medical Box 68760 use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Unknown i signed by the at Id be detached fo 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Surveise Assisted 1 Yes 2 Mo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier (Check only one)

Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. FREDERICK Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Alah Mae Shumaker Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death E6 426 6. Sex 8. Date of Birth (Month, Day, Aug • 15 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕅 F Min. Russelldale, W **Director** 85 Yrs. ,1924 235-32-6274 Aug. Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No WV Mineral Burlington 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 1, Box 137 Rt. 26710 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Receptionist Optometrist Office traumatic event, Be 17. Father's Name (First, Middle, Last) should be file r and Mental Ի ris marked ot 18. Mother's Name (First, Middle, Maiden Surname) မ Crowder Hartman permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Rosanell Shoemaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen M. Wilburn/Daughter 5 Cedarwood Drive Morgantown, WV Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2010 4 ☐ Donation 5 ☐ Other (Specify) Elijah High Cemetery Purgitsville, WV 21. Signature of Funeral Service Lic Smith Funeral Home 22. Name and Address of Facility 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Jepsis disease or condition resulting in death) Tein hours Medical Due to fr as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause Unisease or impory Due to (or as a consequence of): and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar for use as the buris Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Yes been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 perform Yes 2 No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Tes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

DHMH 17 Rev 7/2009

State Registrar Ama Shali

Shakil,

Huma

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Cumberland, MD

625 Kent Avenue

20/10

21502

MI)

DHMH 17 Rev 1/2001

State Registrar

30. Name and address of pe MOI

31. Date filed (Month, Day,

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son who completed cause of death (Item 23a) (Type, Print)

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32. Registar's Signature

29c. License number

29d. Date, signed (Month, Dav. Year)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Red: No

DHMH 17 Rev 1/2001

State

Registrar

Alan R. Segal,

31. Date filed (Month

M.D.

1 - For State Registrar

parker

Silver Spring, Maryland 20906

1517 Hugo Circle

32. Registrar's Signature

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Baltimore,	permit. Pages 1 end 2 should be Department of Health and Mental Important: If Item 27 Is marked ent vijury or other traumatic ev one.		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐	Removal from S	State	Place of Dispo cemetery, cren	natory or oth	ner place	' I		ate	200	. Location -	City or To	own, State	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 17, Physician/ ROSE J. 20**1**0 1:45 рм SAUL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Silver Spring 3310 N. Leisure World Blvd. # 723 Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🔯 F 578-07-5730 93 Marnth, 784, 1917 Washington. Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shorraumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔽 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 3310 N. Leisure World Blvd. # 723 20906 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced Specify: White Year or Dates. Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur ury or other traumatic event, the Medical I ury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Beauty / Barber Supply <u>Co-Owner</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph Jacobs Helen Hoddes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3900 Thisbe Ct. Olney, Md. <u>Judith Pogue / Daughter</u> 20832 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) <u>Judean Memorial Gardens May 10.</u> **201**0 Olney, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, 4400 Powder Mill Rd. Beltsville, N Mon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End Stage Dementia disease or condition months) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician and for use as the burial-Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed? Yes 24 No 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 💢 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death nours after death.

neral Director: After the filled in by the funera 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pendina work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours To the Funeral I Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D43202 May 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlene Ozanne Blankfard 3305 N. Leisure World Blvd. Silver Spring, MD 20906 State Registrar

			For State RegistraMFND#10eperFH	State of Ma			artment o			ınd M	-	giene	10 1	6721
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9	or ite	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🕅 No		1	1 ⊡ Yes 20X		Specify:	, r deito	riicari, etc.)		Black, White Specify:	
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21215-0036	within 72 hours after death with the Maryland ene. than "naturei", or items 23e or 28e-f show I a Madical Examinar must be malified at	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece (Give	dent's Usual C kind of work of DO NOT use i	ocupati done dui retired)	ion nng most	of worki	ng	16b. Ki	ind of Business/I	ndustry
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þ	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "naturel", or items 23s or 28s-f show event, it a Medical Examiner must be notified at	Bec	17. Father's Name (First, Middle, Last)							r's Name	(First, Middle	, Maiden		
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or or	iges 1 ar of Hea if item or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		Ce	metery, crer	natory or othe	r place)	-					1 1 1 1 1
Baltimore,	permit. Pages 1 Department of H important: if ite any injury or ot ance.		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		Non	beck 1	Nemoruo	U P	R. C	05/1	2/2010) د الد () به د	lney, M	laryland l Home, Inc.
Ba	perm Depa impo any i		Nancy A.	To com	\\	Ve 11	800 Ne	w Ho	umpsh	ire	Ave.,	Silv		ng, MD 20904
			23a. Part1. Enter the disease, or com shock, or heart failere. List only Immediate Cause (Final					f dying,	such as o	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a		r's Di	sease							
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8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	•	d							-			
9 x	leath certifica attending ph I for use as th	/Me	IF FEMALE:	23c. If yes, outcome of	f pregnar	ncy							23d. Date of deli	VAIV
Вох	death atten	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 2 4 ☐ Pregnent at t	Fetal	death 3	Ectopic pregi Other (speci						Month	Day Year
P.O.	t the d by the lached	hysi	9 Unknown	9□ Unknown							···-			
ď.	es tha igned I be det	by P	Part II. Dther significant conditions of	ontributing to death but	t not resu	Ilting in the u	nderlying caus	e given	in Part I.		23e. Did 1	obacco u	ise contribute to	the cause of death?
ord	w require been signal	ted									1 🗆	Yes 2	□No 3□Pro	obably 4 20Unknown
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		ပ်									perio	rmed? 2 🔯 No	death? 1 ☐ Yes	2 No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other:			(Check only			
o	Phys r this ral di	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatien	-	ER/Outpatien 28b. Time of			4 (A) Nur		ne 5 Resi 28d. Describe		6 □Other (Spec	cify)
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Division	Attendi r death. ector: A by the fu	ifice	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of Injul	ry - At ho	me, farm, str	eet, factory, o	ffice			28f. Location (City or To			ral Route Number,
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	To the Hospital or Attendia within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	edical	29a. Certifier 1 💢 Certifying Ph (Check only one) 2 🗀 Medical Exer	ysician: To the best of niner: On the basis of and manner stat	examinati	wiedge, deat ion and/or in	occurred at the vestigation, in	he time my opir	, date and nion, deat	d place, a h occurre	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	0 0		1	29c. L	icense r	number			29d. Dat	te signed (Month	n, Dey, Year)
	1		alan	K L	40	Vin	1	D	5226	1		ħ	May 9, 2	2010
-			30. Name and address of person who						-					
				MD, 1517 H	ugo i	Circle	, Silv	er:	Spriv	1g, 1	Marylar	id 20	906	
	Sta Registr		31. Date filed (Month, Day, Year)	MD, 1517 H	s signat	for	الميا							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Patricia Ann Sweeney 9:56AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 577-34-1072 1 M 2 XF 82 Months Days Hours Min. Janth 24 1928 OFFE'C'Y) Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important I fleem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's Greenbelt 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? Funeral 116 Greenhill Road 20770 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Mamied ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Orland Rader Mary Bernadine Bryson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod Susan Justin -daughter 6870 Denmar Lane Sunderland, Maryland 20689 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 5/8/2010 Alexandria, Virginia Signature of Funeral Service Licepece Bonald V: Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, V150 Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any leading to immediate. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-transit Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 X No 2X No 1 Yes B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: မ 1 ☐ Yes 2 ☐ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 1 X Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury ☐ Accident ☐ Suicide 1 Yes 2 No Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined hin 24 hours a the Funeral D mpleted filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🔲 Medican Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of contifier 10

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

Aylin Simsir, M.D. PGHC 3001 Hospital Drive Cheverly, Maryland 20785

. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

10-03796	
David Mark Scott	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

avid Mark Scott		- For State	ate of Mary		Depa		Health				giene	2 () leg. No.	10	16723
Physiciar ledical Examin	1/	Registrar 1. Decedent's Name (First, Midd David Mark								2	Date of Dea Month May 17, 2	ath Dav Y	'ear	3. Time of Death 2208 hrs
		4a. Facility Name (if not institution 3041 October Place	on, give street and	number)		4	b. City, To Waldor		ocation of	Death		4c. Count Charle	-	
Funeral Director		5. Social Security Number 212 15 3172	6. Sex		(In yrs. Ia 37	ast birthday) Yrs	If Under Months	1 Year Days	If Under	24Hrs. Min.	8. Date of Bi	1973	Foreig	thplace (State or Washington DC untry)
the Maryland a or 28a-f show any idfied at once,	Director	Usual Residence of Decedent 10a. State MD 10b. County 10c. Street end Number 1041 H.	Charles October Pl		Oc. City,	Town or Locati	orf 10f. Zip C	ode 0602				10g. Citizen of V		•
s afte	by Fune	11. Marital Status 1 X Never Married 2 M 3 Widowed 4 Div 15. Decedent's Education (Spe	arried Armed 1 Ye vorced If Yes, Give or Dates:	Year	X No	If Y	es, specify Yes 2	No Cuban, I	Mexican, F specify: on (Give kir	Puerto R	ork done	W!	nite, etc. ^{y:} Whit	
0036 within 72 ho iene. er than "ns Medical Es	Completed	Elementary/Secondary (0-12)	1	(1-4 or 5+)	Disable	ost of worki					N/A		
e, MD 21215-0036 I and 2 should be filed within 7 Health and Mental Hygiene. item 27 is marked other than r traumatic event, the Medica	å	17. Father's Name (First, Middle William H. S 19a. Informant's Name/Relations	cott, Jr.			I 19b. Mailine	Address		Gab	riel	le F. Bu	Maiden Surnar Itler mber, City or To		a Zip Code)
e, MD		William H. Scott	, Jr. (Fat			15801 Place of Dispos	Candy ition (Name	Hill	Road,	Upp		oro, MD	20772	Town, State
Baltimore, permit. Pages I ar Department of Her Important: If ite injury or other tr		1 X Burial 2 Cremation 4 Donation 5 Other S 21 Signatul of Funeral Service	pecify:	I from State	7 I	Thomas	Church	ddress o	of Facility	Lee :	Funeral	Upper Home,Inc	Mar1bo	oro, MD 3 Old Alexandri
Physician /Medical Examiner		23a. Part I Enter the disease, or failure. List rily one cause Immediate Care (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	on each line. a. Diab Due to (or a	etic s a conseq	keto	Do not enter to acidos:						rest, shock, or	heart	Approximate Interval Between Onset and Death
e executed cian and cial - transit	dical Examiner	(Disease or injury that initiated events resulting in death) Last X UNPENDED	d.			g905 7,	/1 /10	ጥጥ						
Sox 68760 death certificate te attending physical for use as the bu	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	23c. If ye 1 Liv	os, outcome e birth egnant at tir known	of preg	nancy 2 Fe	tal death	3	Ectopic p	oregnan	icy	23d. Date Month		y Day Year
P.O. es that the gned by	Completed by Phy	Part II. Other significant condit	tions contributin	g to death t	out not re	esulting in the u	inderlying c	ause giv	ven in Part	11.	1 Ye	es 2 No s an 24l spsy ormed?	3 Pro b. Were a prior to death?	the cause of death? bably 4 Unknown utopsy findings available completion of cause of
of Vital Records, ig Physician: The law require the this certificate has been sincred director, page 2 should	Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	ll Hospital:	Inpatient	2	ER/Outpatient			of Death (C			2 No	1 V Y	
on of Verding Physiath. or: After the funeral of t	ation: To	27. Manner of Death 1 Natural 5 Pen	ding	ate of Injury		28b. Time of I		c. Injury	at Work?	7		how injury occ		
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fill	Certification:	3 Suicide 6 Cou	stigation 28e. P		ry - At h	ome, farm, stre	et, factory, o	office bu	ilding, etc.		28f. Location or Town,		mber or R	ural Route Number, City
To the Hos within 24 h To the Fur	edical	one) 2 Medical Exa	and mann	is of exami			tion, in my o	pinion,	death occ			e and place, an	d due to t	he cause(s)
4		29b. Signature and title of certifi			/	11)		License O.C.M	number			May 18,		onth, Day, Year)
		30. Name and address of person Russell Alexander ME	D. Assistan	Medica	l Exan	niner 111	Penn St	reet, E	Baltimor	re, MD	21201			
Sta Registr		31. Date filed (Month, Day, Year)		Registrar's		1. pa	Kel					0.0	7442	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Tipton Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Allegany Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) MD Days Min. Hours 1 □ M 2 □ F Jun 2. Director 216-38-2134 70 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Allegany Cumberland 1 Cyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13514 Brice Hollow Road 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 1957 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 1957-1965 3 Widowed 4 Divorced white Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 7. Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) machinst ABI Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles William Tipton Elmira (Morton) Tipton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Tipton wife 13514 Brice Hollow Rd. Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of h Important: If ite any injury or ot Date cemetery, crematory or other place Sunset Memorial Park 1 X Burial 2 Cremation 3 Removal from State 5/22/2010 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Sonature Funeral Service Idenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ an(vua (ancel disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) ending physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been signal 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 1 Natural 2 Accident Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 5 Pending n 24 hours after death.

• Funeral Director: Aft eleted filled in by the fur 1 Yes 2 No Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed 3 E Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IKRAMADITYA POONAL M.D 974

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20<u>10</u> Annie Bet Traynham 12, 8:30 PM May Medical 4a. Facility Name (if not institution, give street and number) Fort Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Health&Rehabilitatioh Fort Washington rince Georges 7. Age (In yrs. last birthday) 93 Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Min Director 231-48**-**9890 rginia Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location
Washington within 72 hours after death with the Maryland 10d. Inside City Limits Director DC 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1912 Frederick Douglas Ct SE 20020 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. b 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Black Specify: Completed 3X Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sorter Tomato Factory permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, ttl once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gordon Taylor Ora Lee Adams 19a. Informant's Name/Relationship (Type, Print)
Daughter
Margaret Jennings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) For 20744 8402 Indian Head Hwy., Apt AlWashington, MD 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Christan Tabernac Baptist Cemetery Burial 2 ☐ Cremation 3 ☐ Removal from State 85/17/201b Nathalie ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Conse Dunn Sons Funeral Washington, 5635 Eads Street NE DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each Interval Bety Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 21/2 No Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manuer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Director: After 28d. Describe how injury occurred work? Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 Old

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

MAY 1 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 8, Mary Frances Rowsey Taylor 2010 12:00P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11430 Lynch Rd. Worton Kent 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F (Month, Day, Year) 7/30/1919 **Director** 220-80-9514 93 VA Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD 1 🗌 Yes 2 💹 No Worton Kent 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11430 Lynch Rd. 21678 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmain. College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ James Edward Rowsey Norann Elizabeth Lipscomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11190 Station Rd. Worton, MD 21678 Doris Bramble/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/12/10 Chester Cemetery Chestertown, MD Signature of Juneral Service Licenses ²² Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 Kuch Of Q Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or confinitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph, sician/ FAILURE CONGESTIVE HEART disease or condition resulting in death) years Medical Due to (or as a consequence of) **Examiner** THEROSCLERO Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION ATRIAL 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a, Was an autopsy performed Yes 2 Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

Registrar

Ms

State

Peer Rd. Chestertown, MD 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4

32. Regi

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 90:49 2010 Anthony David Turner, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death odlos 0 Social Security Number Sex 1X M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. (Month, Day, Year, Director 216-64-7965 55 /21/1955 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ី No MD Queen Anne's Sudlersville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Wilmore Dr. 21668 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: 3 Widowed 4 Divorced **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Material Handling Chemical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Turner Bernice Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Turner/wife 105 Wilmore Dr. Sudlersville, MD 21668 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) James Cemetery 5/13/2010 Chestertown, MD Signature of Funeral Service Licens 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
130 Speer Rd. Chestertown, MD 21620 Buk & 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinate and the death. r respiratory arrest, shock, or heart failure. List only one cause on each # Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence o Examiner Sequentially list conditions, as a consequence of cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Due to (or as a consequence of): the attending physician and that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an was a autopsy performed After this certificate has 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to ✓dical examiner?
1 ☐ Yes 2 ☑No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after deat.

To the Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ٥ 29d, Date signed (Month, Day, Year) 38990 404 Marrel Court, EASTON

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrard, MD, TCHD, 5/11/10, r1s Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** \mathbf{P}^{M} 1:10 EDWARD G. UHL 05 09 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WILLIAM HILL GARDENS **EASTON** TALBOT | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Pay) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 03/24/1918 NJ 92 158-09-8813 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1 □Yes 2XINo Director OXFORD M TALBOT. 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 21654 28332 BRICK ROW DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CHIEF EXECUTIVE OFFICER **AEROSPACE** and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY SCHILLER HENRY IIHI. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 137 13TH ST. NE, WASHINGTON, DC KIM E. UHL/SON Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 6/8/2010 ARLINGTON, VA ARLINGTON NATIONAL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 21601 JOHN R. 200 SOUTH HARRISON STREET, EASTON, MD MERCERON Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final weeks **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to animediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner executed over-culo and burial-trar Due to (or as a consequence of) physician Box 68760 pe Physician/Medical the as attending IF FEMALE: use a 23c. If yes, outcome of pregnancy
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Baltimore, permit. Pages 1 at Department of Her Important: If ite injury or other tr		21. Signeture of Fundal Service				South 1		Crouch Fu			ry1and21901
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transit	Physician/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at		2 Feta	al death 3 er (Specify)	Ectopic pr	regnancy	Month		ay Year
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F . ¥ . 5	Me	29b. Signature and title of certific	and manner stated.) n	^	29c. Licen	se number		29d. Date si	igned (Mon	th, Day, Year)
		Patrille	Onica-	sell.	la s	0.0	.M.E.		May 18,	2010	
		30. Name and address of person Patricia Aronica-Polla		,	•	111 Penn S	treet Baltin	more, MD 2120)1		
S	ate	31. Date filed (Month, Day Year)		's Signatur			Daiti		-		
Regis		MAY 2	7 2010 Dene	un.	1. 100	arlas					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Year Month May Hiram Fisher Ward 8, 1:50 P. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Prince Georges Clinton 4 1 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye May 29, 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Hours 1 X M 2 1 62 Director 579-64-3190 Washington, D.C. Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits with the Maryland Director Maryland Charles Waldorf 1 X Yes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 9485 Vess Court 20603 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. "natural", or 1 Never Married 2 XMarried Completed by 1 Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mortgage Company Mortgage Lender vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental I မ Hiram Fisher Ward Lisa Maurita Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Silver-Ward (Wife) 9485 Vess Court; Waldorf, Maryland 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important; If ite
any injury or ot May 17,2010 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Øhesapeake Crematory, Inc. Beltsville, Maryland 21. Signature of Funeral Sery 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death LIVER Physician/ CANCER Medical Due to (or as a consequence of): Examiner HE PATITIS Sequentially list conditions, if any, leading to immediate cause. Later Underlying Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CANCER SECONDARY LUNG Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Tes 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after de. ع**ا Director:** A 1 Yes Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I comple

State Registrar

29b. Signature and title of certifier

Date filed (Month, Day, Year,

4 2010

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0064986

29d. Date signed (Month, Day, Year)

9/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY 0^{Day} 2010 **Physician** 11:30A.M Ivy Jane Van Winkle /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Reeders Memorial Home Washington Boonsboro 8. Date of Birth (Month, Day, Dec. 21, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🗓 F 66 1943 Maryland Director 218-54-7305 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 MYes 2 □ No Director Maryland Washington Boonsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 141 South Main Street 21713 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ₺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 ō 1 ∐Yes 2****∑No Specify ģ Specify: White 3 ₩ Widowed 4 Divorced than "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Janitorial Technician 10 Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Morgan Thompson Alice Catherine Niehouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health at Important: If Item 27 is any injury or other trau Sharon L. Thompson / Daughter 17411 Maple Leaf Ct., Hagerstown, MD 21740 Baltimore, 20b. Place of Disposition (Name of Semelery Crematory or other place)
Kesthaven
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State May 13, 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Frederick, Maryland 21. Signature of Fune Service Ligensee Restnaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 recations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or shock, or head failure. List Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) **Physician** Murch myalor /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it dry, leading to instructions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sons Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): burial Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1 □ Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Directors filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 032518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 WYAND DRIVE, KEEDYSVILLE, MARYLAND 21756 301-432-2222 GUEDENET. ROBERT 31. Date filed (Month, Day, 32. Registrar's Signature Year) State

Registrar

WAKIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ $\boldsymbol{10}^{\text{Day}}$ 2010 JOAN VEST WITHINGTON AM 5:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPICE CENTER OF QUEEN ANNE'S CENTREVILLE QUEEN ANNE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Months Days SEPT. T2 Year 927 577-36-9094 82 VIRGINIA Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director QUEEN ANNE'S 1 Yes 2X No MARYLAND CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 137 COVE POINT COURT 21617 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Mamied <u>۾</u> Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) WRITING WINE WRITER permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 JOHN VEST FRANCES NEVILLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES WITHINGTON/DAUGHTER 10505 SAMAGA DRIVE, OAKTON, VA 22124 Baltimore, 20b. Place of Disposition (Name of CHESAPEARETY CREMATION 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 2010 4 Donation 5 Other (Specify) STEVENSVILLE, MD CENTER Signature of Funeral Service Licensee FELLOWS HELFENBEIN & NEWNAM FUNERAL HOME, 408 SOUTH LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Avenia ino my Medical Due to (or as a consequence of): Examiner Mye Collyg/brain Vepry Sequentially list conditions. if any, leading to immediate
Cause Enter Underlying
Cause (Disease or iinjury Due to (or as a consequence of) Examir that initiated events resulting in death) Last Due to (or as a consequence of): bunial-Physician/Medical Box 68760 phy IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ Nto 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Concespire Meny Contin 24a. Was an autopsy 1 Yes 2 No MOURE ☐ Yes 2 🖫 N Hospital or Attending Physician; 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Othe HOSPICE CENTER 1 🗌 Yes 21 No 9 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes after death

Director: A

J in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined n 24 hours after e Funeral Dire eleted filled in b City or Town, State) Medical 1 Cartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010

Registrar

DHMH 17 Rev 7/2009

State

2540 Conserville Ross Conserville

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JEFFLOY

Day, Year)

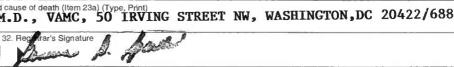
31. Date filed (Month)

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed of

NAVREET KAUR KALLAR, M.D.,



MD# 0101234614

MAY 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 P 1825 4, Alice Kennedy Wright May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Chester River Manor Chestertown Kent Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 DM 2 XE Months Davs Hours Min (Month, Day, Year) 6/28/1916 Country) Director 219-05-9842 MD 93 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 X No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10412 Augustine Herman Highway 21620 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?

1 Yes 2 X No Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White and Mental Hygiene. is marked other than "natural", 3X☐ Widowed 4 ☐ Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner & Operator Cosmetology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 George Lloyd Kennedy, Sr. Blanche Schaffer Groves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) granditem 27 i Page 1 and 2 Susan Wright-Taylor/ 5169 Porters Grove Rd. Worton, MD 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, daught 20a. Method of Disposition Date 20c. Location - City or Town, State permit, Page 1 a
Department of H
Important: If ite 5 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Chester Cemetery Chestertown, MD Signatur Funeral Service Licen ²² Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
130 Speer Rd. Chestertown, MD 21620 Approximate interval Between Onset and Death the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. 23a. Part 1. Enter shock, or heart Immediate Cause (Final Physician terio sclarate and wasce disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Oily to for sella nonsequence of s been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant a 2 1 NO 1 Yes 2 9 Unknown Yes P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury work?
1 Yes 2 No 5 Pending death. 2 Accident Investigation after death filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) fo the Ho., within 24 hours , To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 1000 / WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 8, 2010 Day Milda Lyn Wedderburn 9:05 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. May 14, 1933 Director 579-70-9977 76 Jamaica Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland event, the Medical Examiner must be notified at Director 10c, City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Maryland Rockville Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20850 USA 213 N. Van Buren Street filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: "natural", Specify Black Completed 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. Is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Housekeeper Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Claudius Walker Estella Hall permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diahann M. Adotey/Granddaughter 14000 Castle Blvd., #408, Silver Spring, MD 20904 Date 22, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 22 2010 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 . Signature⊾of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the careth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine and resulting in death) Last attending physician The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 9 Unknown 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: ours after death. leral Director: After this certific filled in by the funeral director, Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 [] No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manny of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral C

completed filled Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medigal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of dertifier 29d. Date/signed (Month. Dav. Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

KHMA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Eva Physician/ Pear1 Arnold Day 2010 Year Month May 26 12:00P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel . Social Security Number 233-38-6634 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 Hours. Oct. 16,2010 West Virginia Director 99 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 132 Bonnie View 21060 Road U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HomeMaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Riley Pack Ida Lilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Willa Nidiffer/Daughter 132 Bonnie View Road, Glen Burnie, MD 21060 Baltimore, Department of Heal 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State any injury or May 28,2010 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Atlantic Crematory permit. Signature of Foneral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation M01580 alla Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) neumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading trimmed cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi signed by the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant a Month Day Year Pregnant at time of death 5 Other (specify) 🗌 Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🌠 No 24a. Was an has autopsy certificate l Yes 2 N completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 2 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year)

May 28 12010 29b. Signature and title of certif 29c. License number D51596 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. Ambalawayay 7845 Oakwood Dakwood Road, aley Burnie, MD 2 106/

A State

Registrar

Ambalawayay

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 2010 9:40P. Howard Aye Anthony 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Gilchrist Hospice Center Baltimore County Towson 8. Date of Birth (Month, Day, May 01 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. 1 ☐ M 2 ☐ F Months 80 1930 Pennsylvania 198-22-2394 Usual Residence of Decedent 10d, Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 No PA. Allegheny County Tarentum 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6284 Route 908 15084 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Serice & Sales of Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed 12 Industrial Scales N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard A. Anthony Gertrude Horne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Carole A. Peterson (Daughter) 306 Overlook Drive Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Fineral Chapel and 20a. Method of Disposition 20c. Location - City or Town, State May 30, 2010 (Harford County) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Forest Hill, Maryland Signature of Funeral Service Licensee Jeffrey L. Gair, Sp. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Center, P.A. 2325 Vork Road Timonium, Maryland 21093-2215 23a. Put it Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Pregnant at time of death

Priysician/ Medical Examiner

or Attending Physician: The law requires that the death certificate be executed

Box 68760

Division of Vital Records, P.O.

Examiner

Physician/Medical

Physician/

Medical

Examiner

Funeral

Director

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ould be filed within 72 hours after death of Mental Hygiene. marked other than "natural", or items

Baltimore, Maryland 21215-0036

Director

Funeral

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equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or linjury at initiated events sulting in death) Last	{	b. —	Due to (or as a consequence of): PARKINS ONS Due to (or as a consequence of):	DISTASE	
	_	d			
FEMALE:					

IF 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No g 🗌 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES
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ficant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco us	e contribute to the cause of death?
<u>s</u>	1 🗆 Yes 2 🗆	No 3 ☐ Probably 4 Unknow
	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

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 >	Part II. Other significant conditions	Ontributing to death but not resulting in the underlying basis given in that is	23e. Did tobacco ase contribute to the obase of death.				
eted by	DIABETES		1 Yes 2 No 3 Probably 4 Unknow				
Complet			24a. Was an autopsy performed? 1 \(\sum \) Yes 2 \(\sum \) No \(\sum \) No \(\sum \) Yes 2 \(\sum \) No				
رة ا	25. Was case referred to medical	26. Place of Death (Check onl	ly one)				
P B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 X Other (Specify) #aSPICE				
	27, Manner of Death 1 Natural 5 Pending 2 Accident Investigati	28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? M 1 Yes 2 No	l. Describe how injury occurred				
Certificate:	3 Suicide 6 Could not 4 Homicide determine		. Location (Street and Number or Rural Route Number, City or Town, State)				

3 Suicide 4 Homicide	6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 (Check 2	Certifying Physici	an: To the best of my knowledge, death occured at the time, date and place, and on the basis of examination and/or investigation, in my opinion, death occurred	and due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s) and manner sta

29a. Certifier	9a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.										
(Check	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state										
only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature a	nd title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05-26-20 Pa 0402 A M Guy A. Bruneau Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 **X** M 2 □ F Min Hours 1 1 1 Day 926 83 217-16-2238 RI Director Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Pacific Grove 1 Yes 2 No CA Monterey County 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 136 Monterey Avenue 93950 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 Midowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Media once. (Give kind of work done during most of working Bel Air Copy & Print life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Jacques Bruneau Annette Lapierre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Bruneau (Son) 1217 Jenny Road Bel Air, MD 21014 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 06-02-2010 Owings Mills, MD Garrison Forest of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to time die cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Month Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably Whitnown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the firector, page 2 s autopsy funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) B Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending work?
1 Yes 2 No Accident
Suicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ Bienert Month Year Raymond Theodore 3 10 PM 05 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 1 🔀 M 2 🗆 F Hours Min. 87 074917-24922 MD 215-16-1739 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Bel Air 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 211 Holstein Ct 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married þ XYes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced Specify: White "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene, ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Steel Worker Beth. Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore J. Bienert Mary Grackowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Holstein Ct Bel Air, MD 21015 Theodore J. Bienert (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley 05-29-2010 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Stepho Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 3weeks ne crotizing

Due to (or as a consequent of). pan creatitis Medical resulting in death) Examiner i week SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached fo g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires prostate cancer, reflux, hyperlipidemia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical å 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No |은 Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1659530533 5/25/10 MD 30. Name and address of person who com eted cause of death (Item 23a) (Type, Print) MD 21201 5 Baltimore Suzanne 22 Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Becker Month Day William 1407 PM May 30 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 21 1933 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 213-32-3217 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State show r 28a-f show notified at 10d. Inside City Limits MD Carrol1 Director Westminster 1 ☐ Yes 🏖 No with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 641 Oak Tree Road 21157 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Mary orces 1 Mary Yes 2 ☐ If Yes, Give Year or Dates: ^{2□No} Korea 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify. \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) machinery machinest 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If Item 27 is marked or any Injury or other traumatic evence. Edward Austin Becker Emily Irene Waters 19a Informant's Name/Relationship (Type. Print)
Mrs. Joyce M. Becker (spouse) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 641 Oak Tree Rd., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 6-1-10 4 □ Donation 5 □ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Paige Haigh P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Abdominal aortic Aneurysm Rupture **Physician** unknown /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if the list in the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a conse gience of I or Attending PhysIclan: The law requires that the death certificate be executed tracted.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 X Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Hospital 1 Ex Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053312 mo 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21044 5755 Cedar Lane, Michelle Henggeler, NO 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9 Ks Physician/ Month Minnie Elizabeth Baker Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carrol1 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) TN 1 M 2 TX Hours June 9. 1916 Director 214-20-8185 93 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at. Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Carrol1 1 X Yes 2 No Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 920 S. Main Street 21074 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced White Year or Dates ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Supervisor Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bobbie Hobbs John Frank Mathis other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4011 Mountain Rd. Pasadena MD 21122 Mrs. Helen Garber (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State - 5 1 X Burial 2 Cremation 3 Removal from State Important: If any injury or True Gospel Cemetery 6/2/2010 Lisbon, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 100764 Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) HRTERIA SC EARS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any Lading to Immedicause. Enter Underlying Cause (Disease or iinjury Directo for as a consecuer or of or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by POGRESSIVE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown EMENTIA completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t Natural 5 Pending work? iniury death 2 Accident
3 Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31/10 Da (663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 447 EAST

State Registrar 31. Date filed (Month, Day, Year)

10-03102						
Dennis Banks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2150 hrs April 20, 2010 Medical Examiner Wayne Banks Dennis c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death St. Marv's 45203 Natscreek Road 45283 Nats Creek Road Hollywood 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 5. Social Security Number **Funeral** Months Days Hours Min Director New York 1 X M 2 F March 23, 194 67 068-34-3437 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No l other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Maryland St. Mary's Hollywood Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Heal and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 這 20636 . A 45283 Nats Creek Road 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 1 Yes 2 X No Specify: White 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year φ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Information Technician 5+ 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julie Reiner Be Deni Banks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 45283 Nats Creek Rd., Hollywood, MD 20636 Christine Mary Banks (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Alexandria, VA Metropolitan Crematory 4/23/10 4 Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650 nuc 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line (Medical Death Hypertensive cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine eauss. Enter Underlying Causs (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last andtransi X AMENDED 4a, Physician/Medical attending physician a X UNPENDED 23a,27 per ME g904 6/3/10 TT The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year Live birth 3 Ectopic pregnancy Month Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. è 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has b performed? . death? 2 No Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be of Vital examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA this 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 27, Manner of Death Certification: 1 X Natural Division 1 Yes 2 No Director: d in by the f Pending within 24 hours after death. To the Funeral Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 21, 2010 O.C.M.E. 30. Name and address of person who pleted cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

31. Date filed (Month, Day, Year)

ORIGINAL

32. Res

strar's Signature

2 MERCANA

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ llis Bowser 5:24 AM Ann 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist buson 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛂 Hours Min 5754 Director 58 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 ☐ Yes 2 ☐ No MD 10e. Street and Number 10g. Citizen of What Country? Funeral 21217 Walbrook Ave USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes : If Yes, Give 2 No Maryland 21215-0036 1 Yes 2 No Specify: Black "natural" 3 ₩idowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) workell Socia Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ elia Wallace mes t. Page 1 and 2 should b tment of Health and Mer rant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wal brook Ave. Baltimore, Important: If iten any injury 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician month disease or condition Medical resulting in death) r as a consequence of: Examiner Sequentially list conditions, iner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death page 2 should be detached 9 Unknow 9 Unknown this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 № No 3 □ Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No Yes 1 Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ျှ 1 🗌 Yes DICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 1 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. I Director: After t Certificate: 1 Matural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by n 24 hours after of Funeral Direc 4 Homicide determined To the Hospital o within 24 hours af To the Funeral D Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature s of person who completed cause of death (Item 23a) (Type, Print) HARUES AARD 31. Date filed (Month, Day, Year) **JUN 0 1 2010** 32. Registras Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28 2010 Year Physician Month Donald Edward Baker May 2:25 PM/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carrol1 Dove House Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Date of Birth (Month, Day, **Funeral X** M 2 □ F Months Days Hours 74 216-34-6431 Mar 2, 1936 Director Ohio Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Exar sher riust he notified at 1 ☐ Yes 2√GNo Directo MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Pages 1 and 2 should be filed within 72 hours after death with 1981 Sams Creek Rd. 21157 United States "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Pyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Harried Baltimore, Maryland 21215-0036 White þ If Yes, Give Year or Dates: Korea 1 ∐ Yes 2XIX No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho
Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natur.
any injury or other traumatic event, In Medical.
once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Disability Office Social Security Admin. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Baker Olive Stamper ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1981 Sams Creek Rd. Westminster, MD 21157 Katherine M. Baker (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/31/2010 Ebenezer UMC Cem. Winfield, MD 21. Signature of Funeral Service 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, P.A. Kelly 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final pulmonary **Physician** cordio -24 45 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cords my oper Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Yea Day 5 ☐ Other (specify) 1 Tyes 2 TNo certificate has been signed by the ector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dire 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 058736

Registrar
DHMH 17 Rev 1/2001

State

Sinte 344

Westminster un 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Zalinen Kahn mo

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** John Calvin Lee Burns May 24, 6:10 A 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1[XM 2□ F 404-20-1778 Director 84 June 3, 1925 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 28a-f Maryland Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò or items 23a 731 Carsins Run Road 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White à 1 ☐ Yes 2 XNo Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Head Custodian Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Willie Burns Ethel Harrison Brown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Burns / Wife 731 Carsins Run Road, Aberdeen, Maryland 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H.
Important: If Iten
any injury or oth Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gdn. 5/28/2010 | Aberdeen, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. funeral Service License 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence oi). cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 2 No 1 ☐ Yes 1 □ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ≥ ER/Outpatient 3 □ DOA 1 Inpatient this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 ☐ Pending investigation Division Natural 2 Accident 1 ☐ Yes 2 ☐ No or Attend after death Director: death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifi 29d. Date signed (Month, Pay, Year) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 25, ^D201<u>0</u> Bertha Anna Bethea 9:25 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery General Hospital 01nev Montgomery . Social Security Number 6 Sex Funeral 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 E Months 97 Hours January 30, 1913 577-03-3944 Washington, D.C Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10h Counts within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15400 Bassett Lane #3E 20906 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes If Yes, Give 2 X No White 1 Yes 2 No Specify: "natural", Specify: Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Department of Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Commerce Be should be filed permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman F. von Bernewitz Louise M. Clos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Philip Padgett/Son 12307 Brandywine Road, Brandywine, Maryland 20613 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of May 30, 2010 20c. Location - City or Town, State Montgomery Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue

Rockville, Maryland 20850 4 Donation 5 Other (Specify) Signature of Euneral Service Licenses M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final ATHEROSCLEROTIC Onset and Death Physician CARDIOVASCULAR disease or condition resulting in death) 4/2ARS Medical Due to (or as a consequence of) Examiner ONGESTIVE Democratistly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Vear Pregnant at time of death 5 Other (specify) g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? EMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?
☐ Yes 2 12 No death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Yes 2 🗌 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work Accident Investigation 1 Yes 2 No Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tipe of certi 2010 son who completed cause of death (Item 23a) (Type, Print) Name and address of ILIP DR. 18/01 PRINCE HERRIN 31. Date filed (Month, Day, Year State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dorothy Ly1e 8:35 AM 2010 Medical 05 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Medical Center Dashinston Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Country Missouri (Month, Day, Year) 03-04-1915 Director 95 218-28-2768 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7874 Poplar Grove Road 21144 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3X Widowed 4 □ Divorced Completed Specify: White Year or Dates. the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work using Jife DO NOT use etired)
Christian Science
Practitioner Elementary/Seconday (0-12) 12 College (1-4 or 5+) Ministry Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, in once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George Grace F. . Ilria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Lester R. Bowen / Son 7874 Poplar Grove Road Severn, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 05-29-2010 Glen Burnie, MD ure of Funeral Service Elcensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Due to (or as a consequence of): disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a nonsequence of): burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: completed filled in by the funeral director, page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ❷No Be 26. Place of Death (Check only one) Hospital: Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work?
1 Yes Accident Investigation 2 🗌 No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie, 301 HOSPITAL KHAWAJA A-FAROOD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 Registrar

Dogothy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** John Radway Bailey 740 6107 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dove Hosue Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday Days 1 X M 2 □ F Director 217-50-7081 60 July Maryland 5, 1949 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Proportant: If item 27 is marked other than "natural", or Items 23a or 28a-f shou any injury or other traumatic event, Ite Medical Evanificational to collifications. Carroll Finksburg 1 ☐Yes 2 V No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1573 Deer Park Road 21048 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) farming agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Washington Bailey Laura Louise Logue ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Berry/sister 1573 Deer Park Road; Finksburg, Maryland 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board; 655 W. Baltimore Street
Baltimore, Maryland 21201 23a. Part 1 Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, a heart failure. List only one cause on explicit. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10415 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 🗌 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy perform To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate ha completely filled in by the funeral director, page. death? 2 □ No 1 □Yes ☐Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) are manner stated. (Check only 29b. Signature and title of certifier 30. Imme and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date feed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2ciO 950 AM OSPDH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard County General Hospital Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Sept 17 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Min 022-03-4241 1 🕅 M 2 🗆 F 92 **Director** MA Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I frem 27 is amarked other than "natural", or items 23a or 28a-f sho may injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MA Suffolk Dorchester 1 Tes 2 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 59 Mercier Avenue 02124 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. δ 1 Never Married 2 Married Yes 2 No WWII 1 ☐ Yes 2 X No Specify: Completed 3 → Widowed 4 □ Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) water quality control water engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Patrick Joseph Conley Mary Agnes Farrel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Murley (daughter) 306 Parade Rd., Box 247, Barnstead, NH 03218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 X Removal from State 6 - 4 - 10St. Joseph Cemetery Boston, MA 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Daige Harget Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ant Litula. Medical To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit

Physician/ **Examiner**

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760

Division of Vital

Physician/Medical å Medical

	resulting in death)	a. Tiorio - Chilling	11141			
		Due to (or as a consequence of):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events					
1 100	resulting in death) Last					
I y Storie in in in in	IF FEMALE: 23c. If yes, outcome of pregnancy 1			23d. Date of del Month	livery Day Year	
1 600 000					the cause of death?	
				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
≀	25. Was case referred to medical 26. Place of Death (Check only one)					
	examiner/ 1					ify)
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be		28c. Injury at work? M 1 Yes 2 No	8d. Describe how inju	ury occurred	
	4 Homicide determined		factory, office	28f. Location (Street a City or Town, Star		ral Route Number,
	(Check 2 Medical Exam	vsician: To the best of my knowledge, death occ niner: On the basis of examination and/or investigat rse Practioner: To the best of my knowledge, deat	tion, in my opinion, death occurred at	the time, date and place	ce, and due to the	cause(s) and manner stated
1	29h Signature and title of certifier		20c License number	204 5	late signed /life att	Day Voas

20066515

5755 Cedar Lane, Columbia, Md 21044

2010

State Registrar

ours after death.

neral Director: Aff
filled in by the fur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Alice 02004M 2010 0: /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number, 4b. City, Town, or Location of Death Éxaminer Baltimore Envoy of Pikesville NursingHome Pikesville 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2€ F 84 Director 095-32-2932 Oct. 1, 1925 Panama Usual Residence of Decedent 10c. City, Town or Location fshow 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sho dical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Sudbrook Lane 21208 U.S.A. Funeral within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Y√Yes 2□No Specify: Panamanian þ Specify: Black 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 . Pages 1 and 2 should be filed wi frment of Health and Mental Hygien tant: If Item 27 Is marked other th Jury or other traumatic event, the Seamstress Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Frances White George L. Grazette 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Smith/Granddaughter 1724 Carriage Circle, Severn, Maryland21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ott
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville Cemetery 5-17-10 4 ☐ Donation 5 ☐ Other (Specify) Lynbrook, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 has autopsy performed? Yes 2 No certificate 1☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director; A completely filled in by the fu death. 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) X and manner stated. CRNP 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ch, con

To T within

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 0 1 2010

Registrar's A. Jacks

mens

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Clement 25 Wayne Cug1e May 5:00 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Heritage Harbour Nursing & Rehab Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 X M 2 - F Months Days Hours 040nt29ay14950 **Director** 59 212-58-8221 Usual Residence of Decedent shov with the Maryland 10a. State 10c. City. Town or Location or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 🗌 Yes 2 🕱 No MD Howard Hanover ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 6611 Railroad Street 21076 "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed 3 Widowed 4 X Divorced Specify. White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Owner;Operator General Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Anna Miller Clement Henry Cugle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trae 155 Caspian Drive, Grasonville, Maryland 21638 Jeremy W. Cugle - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 05-28-2010 Glen Burnie, MD 4 Doration 5 Other (Specify) Atlantic Crematory 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signat MMP, Inc., 7250 Wash. Blvd.,Elkridge, MD 21075 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final de Cell Carcinoma Onset and Death OF Physician/ disease or condition Medical resulting in death Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a onsequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe ☐ Yes 25. Was case referred medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗷 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation Could not be Suicide 6 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D80641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Knows L. Cabanathi 201-105 Back fliver muck Road Balhmore May land

Registrar DHMH 17 Rev 7/2009

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CARNES Month MAY 0620 PM 010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Maryland of Medical Center Baltimore 11 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F (Month, Day, Year) Director 212-82-2865 16. Mar 1969 England Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore XX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3923 Falls Road 21211 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married Yes 2 YNo Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: White 3 Widowed 4 Divorced Specify. h and Mental Hygiene.
T is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Plumbing Company 12 Be and 2 should be filed the Health and Mental Hyg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Paul Elvin Carnes Sandra May Schaeffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Chambers Sister 3406 Abbie Place, Baltimore, Maryland 21244 If item 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If itel
any injury or oth 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6/1/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of disease or condition resulting in death) eumoperitoneum Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year should be detached 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by encephalopathy 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performe of Vital ain 24 hours after death.

the Funeral Director: After this certific

upleted filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 101 2 No Other: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pendina Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral I Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier P 24322 2 Tarian 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #17 & 18 per AB G904 678/10 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 3. Time of Death Decadent's Name (First, Middle, Last) 2. Date of Death Physician/ ummina Medical 4a. Facility Name (if not institution, give street and number) Examiner n, or Location of Death 4c. County of Death 5. Social Security Number **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Hours Min April 21 Year) 1919 218-07-0891 Director 91 Yrs. Oklahoma Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Charles Street; Apt 700 524 N. 21201 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. ģ 1 🔀 Never Married 2 🗌 Married Baltimore, Maryland 21215-0036 white "natural". If Yes Give 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 2 Forrest Cummings Forest Cummings Dora Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Cummings/nephew PO Box 25; Rico, Colorado 81332 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Signature of Funeral Services S Wade 22. State Anatomy Board; 655 W. Baltimore Street Director 2221/1 Baltimore, Maryland 21201 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line.

Immediat X ause (Final Approximate Interval Between Physician/ disease or condition resulting in death) Medical Due to (as a consequence of): Examine meurin Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated systems ue to (or as a consequence of) Examir anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Year Pregnant at time of death Day signed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Renal Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 Mo To the Hospital or Attending Physician: 'within 24 hours after death.'
To the Funeral Director: After this certifies 25. Was case referred to medical of Vital æ 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Ponpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division within 24 hours after death.

To the Funeral Director: Al completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 30. Name and address of person who completed e of death (Item 23a) (Type, Print) State Registrar

or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Hospital

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

"natural"

Baltimore, Maryland 21215-0036

physician and is the burial-tran certificate eral Director: A filled in by the fi 24 hours e Funeral within 24 hor To the Fune completely fi

4 Homicide	determined	building, etc. (Specify)	actory, office	28t. Location (Street and Number of Hural Houte Numb. City or Town, State)				
29a. Certifier (check only one)	1 Certifying Physi 2 Medical Examin	clan: To the best of my knowledge, death occ er: On the basis of examination and/or investi- and manner stated.	surred at the time, date and place gation, in my opinion, death occu	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)				
29b. Signature and	I title of certifier		29c. License number RES-000	29d. Date signed (Month, Day, Year) 5129/10				

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Medical

MOHASSEL 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Deat 3. Time of Death Month **Physician** Nico AM na NOON NO10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) . Age (In vrs. last birthday) Birthplace (S Country) ate or Foreign **Funeral** 15 M 2 - F Months Days Hours Min 214-58-8460 60 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No Director more 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21218 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give 1 Yes 2 No Specify. 2 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. Do NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ns nce ura 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pobsor paleon <u>0</u> ernon leasan 10 19b. Mailing Address (Street and Nur ber or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type. Print) State, Zip Code) laine he 1510 20a. Method of Disposition 20b. Place of Disposition (Name of Location City or Town, State 20c 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory 21. Sign of Funeral Service Lice ar Hol Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final Uncar **Physician** disease or condition resulting in death) /Medical Due to (or as nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Urden ing Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician an Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No detached signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 2 No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No M Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) After Natural Natural 5 Pending investigation Injury 1 Yes 2 No eral Director; At filled in by the fi 2 Accident after death. 3 Suicide Could not be 28e. Place of injury - At hon building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) 24 hours 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29b. Signature and title of 29d. Date signed (Month, Day, Year) License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) (o Maria 1 lorale 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Sign State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (Fixst, Middle, Last) 2. Date of Death 3. Time of Death May 28, Year **Physician** 2010 10:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Elkridge 6520 Tufts Drive 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 12–14–1969 **Funeral** Days Months Hours 1 € M 2 □ F 40 **Director** 214-86-2499 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Elkridge MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'natural", or Items 23a or United States 21075 6520 Tufts Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Item 1 Never Married 2KM/Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner-Operator Fence Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Garofolo Troy Davis ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6520 Tufts Drive, Elkridge, Maryland 21075 Christina Davis - wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06-01-2010 Elkridge, Maryland Meadowridge Mem. Pk. 21. Signatule of Funeral Service Licen 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash Blvd., Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Metastalic **Physician** MENO Carcinomi /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine any, leading to infinedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical or Attending Physician: The law requires that the death certificate IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 9 Unknown been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate Division of Vital 2 No 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical (Check only one) and manner stated. within 7 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

MO

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** MAY 21, 2010 3:54 P M THOMAS BULLARD DABNEY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL BAY WOODS of ANNAPOLIS **ANNAPOLIS** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral XX**M 2 F Days Hours Yrs. Director 444.40.6392 97 APRIL 23, 1913 **ARKANSAS** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. Count 10c. City. Town or Location r 28a-f show 1. Yes 2 No Director ANNE ARUNDEL **ANNAPOLIS** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral', or itsms 23a or Examiner reust be 7101 BAY FRONT DRIVE APT. 401 21403 Pages 1 and 2 should be filed within 72 hours after death by Funeral 12. Was Decedent Ever in U.S.
Artied Forces?
1(±1)Yes 2 □ No
If Yes, Give
Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 XXNo Specify: Specify: 3 Widowed 4 Divorced "natural", Completed er than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ U.S.GOVERNMENT MILITARY MAN other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be marked CHARLES DABNEY 2 LORA CORINNE BULLARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 DAVID B. DABNEY SON 920 CREEK DRIVE ANNAPOLIS, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of H important: if Ite any injury or ot once. 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BAYVIEW CREMATORY , INC 5.25.2010 BALTIMORE, MD 21. Signatura Sunergly concell transes 22. Name and Address of Facility FINK FUNERAL HOME, P.A. K. CREGORY M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Enter the disease, or o Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** men; /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed sicien and burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🖪 No 1 TYes 2 🗆 No : After this certific funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation M 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours after To the Funeral Dire 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Koli

ar

JUN 0 1

31. Date filed (Month, Day, Year)

12200

Annapolis Rd # 228 Glenn Dale MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26^{Day} Physician/ MAY 20 ĬŨ 8:15 A Opal Gertrude Davis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL 9. Birthplace (State or Foreign Year If Under 24 Hrs. 8. Date of Birth If Under Social Security Number 6. Sex 7. Age (In yrs. last birthday) 5^{Year)}1923 **Funeral** Country Virginia NOV. 26 Days Min. 1 □ M 2 🔀 F 86 219-18-0583 Director Usual Residence of Decedent items 23a or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 X No Abingdon Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21009 305 Overview Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Was Decedent Ever in U.S. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Yes 2 No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Cafeteria Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vada (nmn) Newman Emmitt (nmn) Maners 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 305 Overview Drive, Abingdon, Maryland 21009 Ronald Davis / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Bel Air Memorial Gdn. 6/2/2010 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig ture 22. Name and Address of Facility McComas Funeral Home, P.A. African Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician/ end stag disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): **To the Hospital or Attending Physician:** The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) David 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEL AIR, MD. 21014 615 WEST MACPHAIL ROAD DAVID DUNN

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Regis rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 23 Barend A. deVries 2010 2:23P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours Months 84 October 22, 1925 Holland 216-46-8628 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Bethesda 1 ☐ Yes 2 🎛 No 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 8300 Burdette Road 20817 United States items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc and Mental Hygiene. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 💆 No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Economist World Bank Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental of Health and Mental if item 27 is marked rother traumatic ev ည Jacob deVries Metje Verburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine M. deVries/Daughter 6800 Renita Lane, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May Date , Page 1 permit. Page 1 Department of I Important: If it remetery, crematory or other place
Parklawn Memorial 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 2010 Rockville, Maryland Bethesda, Maryland 20814. Pumphrey Funeral Home/Bethesda, Maryland 20814. 21. Signature of Funeral Service Licen Log M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Presumed Myocardial Infarction Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examine Due to (or as a consequence of): Atrial Fibrillation the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 has autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 🔣 N Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 X No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 🖺 Natural 5 Pending death. Investigation ☐ Accident 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Jem 23a) (Type, Print)

Gary Kortizinsky, MD 2141 K Street, NW #407, Washington, D.C. 20037 32. Registrar's Signature

MD15928

May 24, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Alma P. Duerbeck 2010 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore 8. Date of Birth (Month, Day, Ye June 12, 1 Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours 1 M 2 XF 219-05-2491 Director 90 Maryland 1919 Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10a. State 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland Director Maryland Baltimore Parkville 1 Tes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2902 Cub Hill Road 21234 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 📈 No Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Pickett Sarah Driver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Huggins (Daughter) 28 Bristow Court Baltimore, Maryland 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 27, 2010 Parkville, Maryland 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Parkville Signature of Funeral Service Licensee 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last s been signed by the attending physician should be detached for lise as the bearing. Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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5 Other (specify) in the past 12 months?

1 Yes 2 Alo
9 Unknown Month Day Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has page 2 performed?

Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) the funeral director, Be Hospiæ Other: 4 Nursing Home 5 Residence 6 Cher (Specific 2 DaNo 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 164395 eted cause of death (Item 23a) (Type, Print) ZOI N CHAPLES ST, 8WITE 4105 BALTIMITE, MD 21204 31. Date filed (Month, Day, Registr State Registrar

	ın/	Registrar 1. Decedent's Name (First, Middle Douglas Ray Ea	e, <i>Last)</i>		Cer	ndelible Ink a-b . 20 a-c artment of b if G904 6 tificate of L	<u></u>	2. Date of De Month May		20 ^{Year}	3. Time of Deat 5:22
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uneral irector		5. Social Security Numbe	6. Sex 1 ፟፟ M 2 ☐ F	7. Age (In yrs. la 82	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir July 28	th y, Year 927	9. Bird Cor Penn	thplace (State or Fore untry!!!!!! sylvania
show d at	to	10a. State 10b. County			y, Town or Loc						10d. Inside City Lim
· 28a-f notifie	Director		tgomery	· Ga	ithers	Pote	omac				1 □ Yes 2 ₹
23a or st be r	ral	10e. Street and Number 9309 Falls B	ridao Ian	0		10f. Zip Code	20052	20854	10g. Citizer	of What Co	ountry?
r mus	Funeral	11. Marital Status unk			13. V	Vas Decedent of Hi f Yes, specify Cuba				Race - Ame	rican Indian,
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7 is marked c raumatic eve	잍	William Earich				<u>.</u>	<u>Blanche</u>				
27 is trau		19a. Informant's Name/Relations Ayers/5P Anne Ayres/E	ectal ^{Pri} Adm riend	inistrat	то 1 °ь. Избр 930	g Address (Street a	and Number or Ru Be Drive Lidge La	nai Route Numb Marti me; Ga	nsburg thers	vn, State Zi	25401-4695 MD 20877
Important; If item any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 4 ☐ Donation 5 ○ Sther (3 Removal from	20b. P	Place of Disposemetery, crem tgomer	sition (Name of natory or other place um, Inc.	e) Mav	Date 27, 201 0		•	Town, State
Importa any inju once.		21. Sign dure of Funeral Service	wade, 1	Frector							ery Ave. MD 20850
드등리		23a. Part 1. Enter the disease,	1/1/1	Ill						ille,	MĎ 20850
an and minertransit minertransit	Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to	nary Art (or as a consequence of the consequence of	uence of): tery D i	Infarctio isease					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Physician OKI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X**□ F 216-50-4517 60 **Director** 07/02/1949 MD Usual Residence of Decedent Show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f s notified Director MD 1 ☐ Yes 2X No Howard Columbia 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ral", or items 23a or Examiner must be 7008 Knighthood Lane Funeral 21045 U.S.A. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Completed by 1 ☐ Yes 27 No Specify: White 3 Widowed 4 Divorced 'natural' 15. Decedent's Education traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental marked Charles T. Yeager မ Virginia R. Perseghin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any Injury or any 50 Stephen L. Eichhorn/husband 7008 Knighthood Lane, Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 06/01/2010 <u>Glen Burnie, MD</u> 21. Signature of Funeral Service Licenses 22. Name and Address on a con.,
Witzke Funeral Homes, Inc. 5555 Twin Kno11s Rd., Columbia, MD 21045 cation the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 7.1 23a. Parl 1. Enter the disease, or your lication that caused the shock, or heart failure. List may one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** nerniati disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** structure of the struct ntracrania Examine Due to (or as a consequence of) burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical The law requires that the death certificate be the as 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autops has perform 1 🗌 Yes certificate 2 V No 2 🗀 No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 1 🗌 Yes 1 Inpatient 4 \square Nursing Home 2 ER/Outpatient 3 🗆 DOA 5 🗌 Residence 2 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural Time of 28c. Injury at Work? 28b. 28d. Describe how injury occurred Certification: Division or Attending **Director:** After 5 Pending investigation Injury death. 2 Accident 1 TYes 2 No the Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) Hospital 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only within 2 29b. Signati re and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year)

12

Registrar

DHMH 17 Rev 1/2001

State

MARIA MENUCCI
31. Date filed (Month, Day, Year)

ellicoi menuoci, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1. partel

2010

600 North Wolfe St, Baltimore, MD, 21287

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May 28 Day 2010 Year **Physician** 12:00 P M Farmer Doris Ruth /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Howard Elkridge 6391 Rowanberry Court, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06-04-1929 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Days 1 □ M 2 😾 F 213-26-6177 80 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 28a-f show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "motical Examination is used to notified at 1 ☐ Yes 2 No Director E1kridge MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21075 United States 6391 Rowanberry Court, 303 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Childcare Nanny 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in ment of Health and Mental Frances Jones Harold Barton ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3413 Gough Street, Baltimore, MD 21224 Alice Deckman - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of P
Important: If ite
any injury or ot 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 06-02-2010 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Fineral Service Licensee MMP., Inc., 7250 Wash Blvd., Elkridge, MD 21075 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIAC CARS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by HYPERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been rector, page 2 should PERIPHERAL VASCULAR 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an PACEMAKER 2 X No 1 □Yes alorance
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ral Director: After this certificate
*** the funeral director, pr 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) မ 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 ☐ Homicide e Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 22832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5808 MAIN STREET, ELKRIDGE 31. Date filed (Month, Day, 32. Registo State 2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink Figure All Copies Are Legible

homas P. Fitzp		1- For State Amend Item 5 per 1h, g904, 00/0//2	Health and Mental Hy Death	ygiene Reg	2010	6765
Physicia Nedical Exami	an/	Registrar 1. Decedent's Name (First, Middle,Last) THOMAS PATRICK FITZPATRICK		2. Date of Death	Day Year 10	3. Time of Death 1107 hrs
		4a. Facility Name (if not institution, give street and number) 3636 Chesterfield Avenue	4b. City, Town, or Location of Death Baltimore		4c. County of Deat	h
Funeral Director	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	_	Forei	rthplace (State or gn gn puntry) MD
th the Maryland 23a or 28a-f show any notified at once.	Director	Usual Residence of Decedent 10a. State	10f. Zip Code 21213	10g	g. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No untry?
rs after death wi ural", or items miner must be	by Funeral	1 Whever Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15, Decedent's Education (Specify only highest grade completed) 16a. Deceden	Is Decedent of Hispanic Origin? (Spies, specify Cuban, Mexican, Puerto Yes XX No specify: It's Usual Occupation (Give kind of woost of working life. DO NOT use retired.)	Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black, White Vindustry
21215-0036 ould be filed within 72 hou the man Hygiene. s marked other than "nat ic event, the Medical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 1 Insp 17. Father's Name (First, Middle, Last)	Dector 18.Mother's Name	(First, Middle, Ma		ity
MD 21218 d 2 should be fill lith and Mental H m 27 is marked	To Be	, to all the state of the state	Ir Address (Street and Number or F Masters Drive Bal		per, City or Town, Stat	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er		20a. Method of Disposition 1 Burial 2 XXcremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition crematory or other Specify:	ition (Name of cemetery, her place) t Cremaotry 05/2	Date 28/2010	20c. Location - City o	r Town, State , Maryland
Balti Departi Importi		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	lame and Address of Familytche 6500 York Road he mode of dying, such as cardiac o	Baltimon	re, Marvla	nd 21212 Approximate Interval
Examiner	9	failure, List only one cause of each line. Immediate Cause (Final diseas or condition resulting in death) a. Atherosclerotic Cardiovascular Distriction Due to (or as a consequence of):				Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
e executed ian and ial - transit	lical	d. UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicil completely filled in by the funeral director, page 2 should be detached for use as the burit	Physician/Med	past 12 months?	etal death 3 Ectopic pregnather (Specify)	ancy	23d. Date of delive Month	ny Day Year
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cal Records, ian: The law requir certificate has been sector, page 2 should	Completed		26 Place of Death (Check	24a. Was ar autops perform 1 • Yes 2	y prior to ned? death?	
Vital *hysician: *rthis certiful al director	To Be	25. Was case referred to medical examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	t 3 DOA Other Nursin	ng Home 5 F	Residence 6 🗸 Oth	er: Scene
Division of Vital Records, soptial or Attending Physician: The law requirm hours after deard. After this certificate has been sing y filled in by the funeral director, page 2 should by	Certification:	27. Manner of Death 1 ✓ Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	1 Yes 2 No		treet and Number or F	Rural Route Number, City
To the Hospita within 24 hours To the Funera	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	rred at the time, date and place, and tion, in my opinion, death occurred a	d due to the cause at the time, date a	e(s) and manner as stand place, and due to	ated. the cause(s)
F	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (M May 27, 2010	ionth, Day, Year)
			Street, Baltimore, MD 2120	1		
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ranks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:37 AM **EDWIN** May FINK 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A Hospital of Baltimore 6. Sex 1 X M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 07/31/1930 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 577-36-7029 NY Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Directo MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2811 LAURELWOOD COURT 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M/Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 🛣 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "q any injury or other traumatic event, if we wan gince. College (1-4or 5+) Elementary/Secondary (0-12) MECHANICAL ENGINEER MEDICAL TECHNOLOGY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ WILLIAM FINK YETTA RAILUS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2811 LAURELWOOD COURT, BALTIMORE, MD 21209 BETTY FINK / WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 05/27/2010 REISTERSTOWN, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Complications disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Ne phrotic Sequentially list conditions, in your language in the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of): aftending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Renal Cell Carcinome 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA 1 X Yes 2 ☐ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔁 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 124 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D59062

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Belvedere Ave

17.13.

2401

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. O .

25 2010

Baltimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MANY SELMA 2010 FRANK 01:15P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6413 DORAL DRIVE, #C BALTIMORE Social Security Number 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2 🕱 F Days Months 08/03/1915 Director 225-28-3162 94 Yrs **GERMANY** Usual Residence of Decedent items 23a or 28a-f show ler must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Funeral 6413 DORAL DRIVE, 21209 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ?7 is marked other than "natural", or iter traumatic event, the Medic I Examiner 14. Race - American Indian or i Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes If Yes, Give 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER GROCERY STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SIGMUND DREIFUS SUNDERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to ELLEN LIGHTMAN / DAUGHTER 5 FARRINGDON COURT, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State CHEVRA AHAVAS CHESED | 05/28/2010 4 Donation 5 Other (Specify) RANDALLSTOWN, MD e of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications 1 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ phocyTic disease or condition resulting in death) VCGNI 171 Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 nding pure IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending To the Hospital or Attending within 24 hours after death.

To the Funeral Director; Afte completed filled in by the fun 1 Natural ivatural
Accident
Suic iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certi 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Va 2435 West State

DHMH 17 Rev 7/2009

Registrar

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 4:20P M Betty Mae Gear 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Agnes LIMORE 7. Age (In vrs. last birthday If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🛱 F 3-26-1931 West Virginía Director 234-46-3394 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is inclical Examinal must be notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Mary Yes 2 ☐ No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code Funeral 1709 Cole Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 TNo Specify. 9 White 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Montgomery Ward Security Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Fansler Edith Landford ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Bamba - Daughter 1709 Cole St. Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-30-2010 | Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility 21. Signature of Euneral Sc Gary L. Kaufman Funeral Home Inc 7250 Washington Blvd., Elkridge, MD 21075 Approximate Interval Between Onset and Death 185 se, or complications that caused the death. Do not examine. List only one cause on each line. r the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examir The law requires that the death certificate be executed Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No the 9 Linknown 9 Unknown ò 23e. Did tobacco use contribute to the cause of death? Records, ≥ 2 🗌 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? (es 2 2 No certificate 1 ☐ Yes 2 1 No Vital 1 🗌 Yes Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ∐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L ca 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Fxaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signa 29c. License number pleted cause of death (Item 23a) (Type, Prin State Registrar

James Hanson Galford

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		Russell Alex	ander MD.	Assistant i	Medical	Examiner	111 P	enn Stree	t, Ba	altimore,	MD 212	201				
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Regist	rar		JUN 0	2010	A CONTRACTOR OF THE PARTY OF TH		A.	100					OCME			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 10b per inf g905 7-23-10 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Shirley L. Godfrey 7:33 AM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Regional Hospital _aurel aurel George If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Year) 1 ☐ M 2 🗶 F 190-22-5264 82 Yrs. Director January 5, 1928 Pennslyvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the W. Joan Evan, mr. 1985 be notified at Prince George's Director 1∐Yes 2XNo Maryland Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3146 Gracefield Road, #402 Funeral 20904 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Completed by Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and 2 should be filed within lealth and Mental Hygiene. In 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilson Henry ဥ Sarah L. Bennett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Deborah G. Wolff /Daughter permit. Pages 1 and Department of Health Important: If item 27 any injury or other trong. 30 Farm Haven Court, Rockville, Maryland 20852 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 24, Montgomery Crematorium, Inc 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 | Kopert A. Fumphrey Funeral none / Rockvil 300 West Montgomery Avenue, Rockvil 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** hr /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, but immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriet-transit Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ■ No 9 □ Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 5 Pulmonary Chronic Obstructive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Aneurysm Inoracic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 Regional Hospital, 30. Name and address of person who completed cause of the (Item 23a) (Type, Print) Laure) Dept Thomas H. Burguieres oad 31. Date filed (Month, Day, 'Year) 32. Regis State Registrar

10-03964

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Lonnie Grier State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month **Medical Examiner** 1531 hrs Lonnie Grier May 18, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State orunk 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Min. Director 216-58-0520 March 5, 1948 62 1X M 2 F Country) Yrs Usual Residence of Decedent any. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at once, 1 Yes 2 X No Anne Arundel Jessup death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PO Box 549 20794 USA 11. Marital Status unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Was Decedent Ever in U.S. Armed Forces? Unk Race - American Indian, Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 altimore, MD 21215-0036

it Pages I and 2 should be filed within 72 hours after deal utment of Faelin had Mental Hygiene.

vrant: If item 27 is marked other than "nature!" 2 No 1 Yes black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done UNK 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet unk unk 17. Father's Name (First, Middle, Last) UTIK 18.Mother's Name (First, Middle, Maiden Surname)UTIK Be ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street; Baltimore, Maryland 21201 20a. Method of Disposition Baltimore, permit. Pages 1 and 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department Important: Donation 5 \ Other Specify: in state 21. Signature of Fundral Service Licensee Ronald, S. Wa 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 Director Baltimore, Maryland Agrt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** falure. List only one cause on each line. een Dnset and /Medical **Peritonitis** Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Small Bowel Perforation Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit sician/Medical 23a,b,27,28a-f per me g907 9-21-10 vt X UNPENDED AMENDED The law requires that the death certificate be of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) certificate has been signed by the att ector, page 2 should be detached for 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? φ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of director, page 2 performed' death? Yes 2 No 1 V Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 🗸 Inpatient 2 🗌 ER/Outpatient 3 🔲 DOA Other Nursing Home 5 Residence 6 Other ٩ 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Division 5 Pending 1 Yes 2 unknown in by the unknown unknown unknown 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be (Specify) Homicide unknown unknown 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 25, 2010 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day 32. Resistrar's Signature State

OCME

Registra

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			For State of Ma 1 - State Registrar	aryland / Depa Cea	artment of F rtificate of D			ene	0	16112
	Physicia Medic		1. Decedent's Name (First, Middle, Last) JOSEPH W. Gibbs				2. Date of Death	23	18	3. Time of Death
ر اند اند	Examin	er	4a. Facility Name (if not institution, give street and number) Hospice of the Chesapeake		4b. City, Town, or Harwoo	Location of Death		4c. County Anne	y of Death e Aru	
ı	Funeral Director		229-05-9315 1 ² M 2 □ F	(In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, Youne 19,	°1′917	9. Birth	place (State or Foreign ^{ntry)} Virginia
	yland •f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo						10d. Inside City Limits
	vith the Mar 23a or 28a st be notifi	Funeral Director	MD Anne Arundel 10e. Street and Number 701 Glenwood Street Apt 5	Annapol	10f. Zip Code 21401		10	g. Citizen of USA	What Cour	1 Yes 2x No
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ል	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evarmed Forces? 1 Yes 2 Never Married Status 1 Yes 2 Never Married Status	ver in U.S.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)	Bla	ce - Americ ick, White, y: whi	etc.
Maryland 21215-0036	vithin 72 hou jiene. er than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+	(Give	dent's Usual Occup, kind of work done o OO NOT use retired) er		ing 16	3b. Kind of B	lusiness In	dustry unk
yland 2	should be filed vor and Mental Hyg 7 is marked othe raumatic event,	To Be	17. Father's Name (First, Middle, Last) Joseph Gibbs				e (First, Middle, Ma Marie Col		ie)	
Mar	2 shou th and 27 is m traum:		19a. Informant's Name/Relationship (Type, Print) Phyllis Ann Gibbs/wife		ng Address (Street a			-		Code) , MD 21401
Baltimore,	Page 1 and 2 s ment of Health ant: If item 27 ury or other tra		20a. Method of Disposition 1	20b. Place of Dispo				Oc. Location		
Balti	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Smeral Service Linensee Processor State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201							
Ŧ	nysician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a		er the mode of dying	g, such as cardiac o	or respiratory arrest	disea	sl	Approximate Interval Between Onset and Death
00	e be executed ysician and e burial-transit	lical Examiner	cause. Enter Underlying Cause (Disease or linijury that initiated events c.	consequence of):						
. Box 68760	he death certificate be y the attending physicis ched for use as the bur	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome o 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnanc☐ Other (specify)	cy			ate of deliv	rery Day Year
ls, P.O.	law requires that the de nas been signed by the e 2 should be detached		Part II. Other significant conditions contributing to death bu	t not resulting in the u	underlying cause giv	ven in Part I.				he cause of death?
Records,	las 2	Completed					24a. Was an autopsy performe	ed?		ppsy findings available ompletion of cause of
<u>ta</u>	sician: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital:		Othe	ace of Death (Checi				4.4.18.0.41
n of V	ding Phys h. After this funeral di	ate: To	27. Manner of Death Natural 5 Pending 28a. Date of injury (Month, Day,	nt 2 ER/Outpatien y Year) 28b. Time of injury	f 28c, Injury work	4 ☐ Nursing Ho y at	ome 5 Residence 28d. Describe how			MANDRIN
Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director. After this certificate I completed filled in by the funeral director, page	Il Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injurbuilding, etc.	y - At home, farm, str (Specify)		165 2 1140	28f. Location (Stree City or Town, S		per or Rura	l Route Number,
	the Hospit nin 24 hour the Funera npleted fills	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of n Medical Examiner: On the basis of examiner: On the basis of examiner: To the basis of examiner: To the basis of examiner: To the basis of examiner:	ny knowledge, death amination and/or inves est of my knowledge,	occured at the time stigation, in my opinio death occurred at the	, date and place, ar on, death occurred a e time, date and place	nd due to the cause t the time, date and be, and due to the ca	(s) and manr place, and du ause(s) and m	ner as state ue to the ca nanner as s	ed. luse(s) and manner stated. tated.
Þ	vit Con		29b. Signartific and title of certifier H. Kruse	per, mil	29c, License	4 83 8	290	d. Date signe	d (Month,	Pay, Year) [O
			ac Name and address of person who completed cause of de SUSAN H. KRIEGER	ms) 44	5 Det	ense Hu	y Aun	apple	is n	1021401
	Stat		31. Date filed (Month, Day, Year) 32. Registrar	's Signature	ball	,	/	/		

Amend #9 per AB g904 6/1/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9.00 PM Day Month **Physician** 201 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Living sommotion olden Birthptace (State or Foreign Country) 7. Age (In vrs. last birthday) Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 6. Sex 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 1 F 018.12.9509 争) Mass **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ehow. r then "natural", or Iteme 23a or 28a-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2X No Reisterstown MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 3405 Blueberry Lane USA 21136 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) marked other then Hygiene. bookkeeper insurance company 18 Mother's Name (First, Middle, Maiden Sumame) traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 900g. Alfred J. LaForte Lillian V. Tetu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janis A. Hagert/daughter 3405 Blueberry Lane; Reisterstown, MD 21136 20c. Location - City or Town, State 20h Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ronal 22. Name and Address of Facility Board; 655 W. Baltimore Street rector Baltimore, Maryland 21201 Baltimore, Maryland 21201

23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death tmmediate Cause (Final disease or condition resulting in death) malou triton Imanthy Physician /Medical Due to (or as a consequence of): 2 montes Examiner ANOREKIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Zyens DISPOSA attending physician and for use as the burial-transit death certificate be executed HEKIN SOUS 5evere that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Day Year detached for 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown signed by Part It. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 ₩ 3 Probably 4 Unknown been signal Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificate has 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner, of Death Hospital or Attending PI
 24 hours after death.
 Funeral Director; After the letely filled in by the funeral Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ 5/24/2010 D31660 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYNA WESTMIN STER AVE NOR GALVIM STUNGE 291 K-141 3-115 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday) 1 ■M 2 □ F Months Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Syrname) 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OM 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Juneral Service Licensee 23a. Part 1. Ent 1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or host failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy his certificate hil director, page perform Yes 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DQA 4 ☐ Nursing Home 5 ☐ Residence this hin 24 hours after death.

the Funeral Director: After thi

mpleted filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2. 3 Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. CHA J

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 2 Pay 201 gear , SR. HILFERDING 1:55PM LLOYD Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARFORD FOREST HILL HEALTH & REHABILITATION FOREST HILL 5. Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) OH Hours 02-10-1928 Director 297-22-4569 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Harford Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21087 USA 2613 Whitt Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1

Yes 2

No
If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work dane during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Boiler Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arabella Bonar Clarence F. Hilferding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 964 Thompson Rd Fawn Grove PA 17321 Larry Hilferding (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 05-25-2010 Bel Air, MD 21. Signature of Service Lie 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd Bel Air, MD 21015 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ end glag disease or condition resulting in death) Medical Due to (or as a conseque of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No COPP 24a. Was an autopsy performed this certificate has ral director, page 2: 25. Was case referred to medica examiner? **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: After ompleted filled in by the funi work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN -615 W. MACPHAIL RD -BEL AIR, MD 21014 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY Day 8. 10:008 KATHRYN KEMP HAUGHWOUT Medical 4a. Facility Name (if not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Peath timore **Examiner** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Days Hours Min. Director 88 217-12-5729 Apr 6. Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medi al Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore County Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6504 Maplewood Road within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. δ 1 ☐ Never Married 2 🂢 Married ☐ Yes 2 No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hyglene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Residence Homemaker permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumair once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leslie McKinley Kemp Esther Kelbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy N. Haughwout (Son & P.R. 615 Murdock Road, Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Mount Crematory 5/31/2010 Baltimore, Maryland MITCHELL-WIEDEFELD FUNERAL HOME, INC. 21. Signatur Fry Server 7 e Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland Approximate Interval Between Onset and Death T Immediate Cause (Final CARDIAC ARREST Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner VENTRICULAR ARRHYTHMIA Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury CARDIOVASCULAR DISEASE ending physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year the 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of ë 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Certificat Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Sectify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical examiner: On the basis of examination and/or in estigation, in my opinion, death occurred at the time, date and place, and due to the cause Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ttion and/or in estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number DØØ29931 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LORENTZ, CHRISTOPHER M. D. 7601 OSLER DRIVE TOWSON. MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Register's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 05:26 р^м <u>James Randolph Headlev</u> April Medical 4a. Facility Name (if not institution, give street and number)
Anne Arundel Medical Center 4b. City, Town, or Location of Death . County of Death Anne Arundel Examiner Annapolis 7. Age (In yrs. last birthday) 40 yrs. If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-70-7705 1 X M 2 🗆 F Months Days 0476271976 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Director MD Prince Georges Bowie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13802 Old Jericho Park Road 20720 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Roofing Assistant Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be flik Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve မ Wes Headlev Beverly J. Robertson 19a. Informant's Name/Relationship (Type, Print)
Christina Simmons/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 16012 Batson Rd., Spencerville, MD 20868 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other pla Ardent Cremation 1 Burial 2 X Cremation 3 Removal from State 04/29/2010 Hanover, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ardent Cremation 21. Signature of Vineral Servic Censee 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 🗌 No 1 ☐ Yes 2 ☐ 1 Yes 25. Was case referred to medical Medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🖳 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSEPA-HERBERT, IND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MOnth 2010 LINDA RUTH HAYDEN 07:49A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE BALTIMORE TOWSON Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min 1 M 2 X F Months 213-52-5620 1170271948 61 Yrs **Director** Usual Residence of Decedent death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7201 TRAVERTINE DRIVE, #206 21209 12. Was Decedent Ever in U.S.
Armed Forces

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify 3 X Widowed 4 ☐ Divorced Completed Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) during most of working (Give kind of work done life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) SOCIAL WORKER STATE OF MARYLAND Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed treent of Health and Mental H rtant: If item 27 is marked ot njury or other traumatic even ٩ SOLOMON В SCHWARTZ DORIS MAZER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS SCHWARTZ / MOTHER POMONA EAST, #505, PIKESVILLE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB CONG. 05/28/2010 FINKSBURG, MD Sign tyle of Funeral 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final DEOSANLE ^enysician/ bowel or frahm disease or condition Medical resulting in death) Examiner cons UTERINO cancer Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of): than, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ☐ Live Birth 2 ☐ 1 each ☐ Pregnant at time of death ☐ Unknown in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 🗆 No Yes ours after death. eral Director: After this certifica filled in by the funeral director, I To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 NOther (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

only one 29b. Signatur

AMON

31. Date filed (Month, Day, Year)

and title_of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

70

W

32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Pierre Houpt Month 2:30 P.M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 500 Ponderosa Drive Bel Air Social Security Number if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Country)
Maryland 1**X** M 2 □ F Months Days Hours (Month, Day, Year)
May 14, 1930 **Director** 213-26-5879 80 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If frem 27 is marked other than "natural", or from many injury or other fraumatic. "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 500 Ponderosa Drive 21014 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 Married Specify: White 1 Yes 2 No 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physician Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Francis Houpt Marquerite Cecilia Le Bounte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Houpt / Son 826 Highplain Drive, Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Highview Memorial Gdn. 6/2/2010 4 ☐ Donation 5 ☐ Other (Specify) Fallston, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. Signature of Funeral Service Licenses AREF 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final End star Onset and Death Physician/ disease or condition Medical Due to (or as a consequence f): resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, attending physician and for use as the burial-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 g 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 2 No 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 40 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29c. License number D32295 26,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MacPhail Rd., Bel Air, MD 21014

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Nancy E. Healey May 2010 7:00 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 1309 Clover Valley Way Unit D Edgewood Harford County Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year __If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Hours Min (Month, Day, Year) Country **Director** 103-32-5460 69 Feb.06,1941 Bronx.New_York Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Harford County Edgewood 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1309 Clover Valley Way Unit D 21040 United States . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Bank Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Crane Nancy Stringer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Chris Healey 1309 Clover Valley Way Unit D Edgewood, MD. 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel and Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State (Harford Co.) May 29,2010 4 Donation 5 Other (Specify) Forest Hill, Maryland Sorvices 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A.

Wimpulm Manyland 21093-2215 aur. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RESPIRATORY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ULMONARY Caqueritiany list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed EROUS ENDOMETRIAL and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate ! 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 016801 Wellian P.

State

Registrar

9103 Franklin Square Dr.

Baltimore MD 2125

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Amend #17 per rn State of M	aryland 1	Department of F Certificate of		Mental Hy	giene Reg. No.	16	781	
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Phyllis Mary	/ Imbro)		2. Dete of De Month May 2	27, Dey 201	O ^{Year}	3. Time of Death 2:15 PM	
	Examir		4a Fecility Name (If not institution, give street end number)			4b. City, Town, or L					
	Funeral Director		Kingshire Nursing Home 5. Social Security Number 068-05-7233 6. Sex 1 M 2 K F	e (In yrs. lest bi	rthday) if Under 1 Year Months Days	Rockv If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De January		9. Birthpla Countr New Y	ce (State or Foreig	
,	pug	•	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or Location				100	d. Inside City Limits	
	Maryla 1 sho	ō	Maryland Montgomery		ckville			1			
	r 28a	Funeral Director	10e. Street end Number		10f. Zip Code			10g. Citizen of	What Country	y?	
	th wit	ai D	9701 Medical Center Drive		208	850		Unite	d Stat	es	
			11. Marital Status 1 Never Married 2 Married 3 💆 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Give Year or Detes:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	to Rican, etc.) Black, White					
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a	Decedent's Usual Occup	pation during most of work	(ina	16b. Kind of B	usin ess/Ind u	stry	
121	within ene. then	Completed by	Elementary/Secondary (0-12) College (1-4or 5	5+)	(Give kind of work done life. DO NOT use retired	d)	3	Own	U о т о		
d 2	filed v Hygie ther t		10 17. Fether's Name (First, Middle, Last)		Homemaker	18. Mother's Nam	e (First, Middle				
Maryland	should be Ind Mental I	To Be	Vincenzo Vincenzo Re 19a. Informant's Name/Reletionship (Type, Print)	106	o. Mailing Address (Street	Conce	tta Fra	della		- Codel	
	and 2 s saith an n 27 is i		Eugene V. Imbro / Son		3110 Clevela						
Baltimore,	Pages 1 as nent of Hea nut: If Item 3 iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cemete	f Disposition (Name of my, crematory or other place ry Cemetery	cθ)	June 2,	20c. Location	-		
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	101305	22. Name and Addre Robert A. Pur 300 West Mont		ral Home/			20850–2805	
			23a. Part1. Enter the diseese, or complications that caused shock, or heart failure. List only one cause on each lit	the death. Do						Approximate nterval Between	
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition Cardiac	Arrhyt	:hmia					Onset and Death	
		P.	resulting in death) a.	`	consequence of):						
	uted d ansit	Examiner	D		ort Failure				†2	Years	
o,	an an	Еха	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	Due to (or as a	consequence or).						
x 68760,	death certificate be executed e attending physician and of for use es the burial-transit	/Medical	resulting in death) Last								
Box	death certifi a attending I d for use es	iclar	Part II. Other significent conditions contributing to death by	ut not reculting i	n the underduing eques six	on in Part!	22h Did	tohecco ueo co	ntribute to t	the cause of death	
, P.O.	requires that the de neen signed by the a hould be detached	by Physician/M	Pneumonia, Atrial Fibrilla		, , , , , , , , , , , , , , , , , , , ,	en in Part i.		Yes 2□ No	3 ☐ Probe	V	
Records,	_ D 0	Completed b					24a. Was	an autopsy ormed?	avail	e autopsy findings lable prior to pletion of cause eath?	
A.	The lew ate has page 2	E O					10	Yes 2K No	10	Yes 2□ No	
Vital	slan: ertifica ector,	Be	25. Was case referred to medical examiner?			26. Place of Deat	th (Check only	one)	1	Assisted	
ð	ding Physician: h. After this certific funerel director,	on: To	Hospital:	ry 28b.	utpatient 3□ DOA Oth Time of 28c. Injury	4 🗆 Huising He		dence 6 🖺Oti how injury occu		Living	
Division	deat deat ctor: y the	Certification:	2 Accident investigation		M 1 1	M 1 Yes 2 No			ber or Rural I	Route Number,	
_	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical Co	29a. Certifier (Check only one) Certifying Physician: To the best of the Dest	examinetion an	e, deeth occurred at the tin d/or investigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as stel	ted. he cause(s)	
_	To the Within To the	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signe	ed (Month, Da	ay, Year)	
			Ones-		D2	8656		May 27,	2010		
			30. Name and address of person who completed cause of de Ravi Passi, MD 15245 Shady		(Type, Print) Road, Rocky:	ille, Mar	yland 2	20850	2	1.0000	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registry	ar's Signeture	4 1						

10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 7:40 P.M **Physician** Thomas M. Inabinet May 28, 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hart Heritage Assisted Living Street Harford Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Months Days 3 Vrs 8 Oct. 14, 1926 Florida 251-36-5324 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Tyes 20 No Director Forest Hill Bel Air Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21050 United States 205 Kimary Court Apt D Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? NXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White <u>ک</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Defense Contractor Electronics Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sallie Fredonia Zeigler Thomas Dreher Inabinet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 Kimary Court Apt D. Forest Hill, MD 21050 Nell Inabinet / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Evans Funeral Chapel 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2010 Bel Air 2010 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-BelAir 21. Signat of Funeral Service Licensee 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complet tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chonce Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Lectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> Be Completed Certification: To

the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the buriel-transi Division of Vital Records, P.O. Box 68760, signed by the a d be detached for 24 hours a npletely

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examinat must be notified at

Physician

Examiner

/Medical

3altimore, Maryland 21215-0036

Dialites		1 ☐ Yes 2 ☐ No 3 ☐ Probably ◆ Unknow		
under the		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
25. Was case referred to medical	26. Place of Death	(Check only one) Assisted		
examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing Hon	ne 5 Residence 6 Qther (Specify)Tiving		
27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time Injury (Month, Day, Year)		8d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 ertifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated	ath occurred at the time, date and place, a investigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)		

State Registrar

Medical

29b. Signature and title of certifier

Dav. D 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CI Z W. mo-Phs. 32. Redistrar's Signature

29c. License number

032253

29d. Date signed (Month, Day, Year)

May 25, 201, 0

DHMH 17 Rev 1/2001

within 2 To the I complet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per ft 9905 7-30-10 vr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 715 AM awrenc 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 577-32-7066 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1**∑**M 2□F Director AUG 1927 Ohio Usual Residence of Decedent with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 🕅 No Director Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or a 6736 Sharpsburg Pike 21782 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give WWII Year or Dates: WWII 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Dept. of Interior Civil Service Employee traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Herman Kenneth Kugel Rebecca von Kaas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau Thomas E. Kugel/son 93 Appleton St. Boston, MA 02116 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State All County Cremation Services 6/2/2010 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) P.O. Box 195 Sykesville, MD 21784 (410-795-1400) ture of Funeral Service License mysmald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Stage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>2</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has this certificate 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4₺ Nursing Home 5 ☐ Residence 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 🗌 Yes 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier Sy Kenville BONNIES DANK 32. Regist State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month Day 2010 22, 2:35 Hall Katzenbach, Jr. aka Herbert Hall Katzenbach, Jr. Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Springhouse Assisted Living Bethesda Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) June 28, 1909 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 D F Months Days Hours Min. New Jersey **Director** Yrs. 579-48-9917 100 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits rector 1 ☐ Yes 2X No Maryland Montgomery Bethesda 靣 ò 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 4925 Battery Lane #700 20814 United States items ? 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education ye 1 and 2 should be filed wit t of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Herbert Hall Katzenbach Serah A. Buckman 19a. Informant's Name/Relationship (Type, Print) Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814 J. Michael Dougherty, Jr./Rep. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 ⋍ ò 1 Durial 2 X Cremation 3 Removal from State Department of Important; If any injury or Montgomery Crematorium. 4 ☐ Donation 5 ☐ Other (Specify) May 25, 2010 Bethesda, Maryland Inc. 21. Signature A Funeral Service Lice 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc. 7557 <u>Wisconsin Avenue</u>, Bethesda, Maryland 20814 haus Houm M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death
Months Physician disease or condition resulting in death) Cholangio Carcinoma with Obstruction Medical Due to (or as a consequence of **Examiner** Sequentially list nor differs Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and deed be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Advanced Age 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💹 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 2 No 1 Yes ours after death.

leral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 NO Other (Specify) Living Hospital 2 XNo 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred XNatural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number D31319 May 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Avenue #305, Bethesda, Maryland 20814 Loreto S. Albio1, M.D.State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton Crofton Convalescent Center If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗷 (Month, Day, Months Days Hours Min. Penńsylvania Director 1921 165-16-3390 88 Oct. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director 1 Yes XX No MD Anne Arundel Co. Severna Park 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21146 677 Wellerburn Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14, Race - American Indian Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 XWidowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Catalog Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Christian Clements Anna Mae Burrows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 677 Wellerburn Avenue Severna Park, MD 21146 Mrs. Jane L. Burress /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery | 06/03/2010 | Crownsville, Maryland 22, Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee M01121 Services, PA; 1 2nd Ave SW, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysicianz Medical resulting in death) Due to (or as a consuence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Yo
9 Unknown Month Yea 5 Other (specify) Day Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 nknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has perform within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? 2 **N**No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifiei (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifie 29d. Date signed (Month, Day, Year,

State Registrar 31. Date filed (Month, Day, Year)

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DHMH 17 Rev 7/2009

32. Registrar's Signature

	Am	en	d 20a-c, 22, per	e Type or Prin Fh 8904 6/8 State of Ma	ryland / Dep	artment of H	lealth and N	I I Copies Mental Hy	Are Leg	gible.	679	5
			For State Registrar		Ce	rtificate of l	Death		Reg. No.	U .	010	U
	Physici	an	1. Decedent's Name (First, Middle,	Last)				2. Date of De Month		Year	3. Time of D	eath)
ų.	/Medic	_	Carolyn Liebau					May	25	2010	10:45	A ^M
	Examir	er	4a. Facility Name (If not institution, s Harford Gardens		me	Baltimo	_		4c. Cour	nty of Death		
I	Funeral Director		215-48-0558	. Sex 7. Age 1 □ M 2 🖾 F	72 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 21	av. Year)	9. Birthi Coul Mary		Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					I0d. Inside City	Limits
	ne Maryi 8a-f sho ptified af	Director	MD		Baltimo						1 ☑Yes	
	vith ti	Ö	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cou	ntry?	
	s 232 nust	eral	4700 Harford R			21214		i6. V N-	USA	ace - Ameri	on Indian	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ances.	by Funeral	11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	o 13.	was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Specify Yes or N if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2☑ No <i>Specify:</i>			lack, White,	etc.	
ş	thou attura	ed	15. Decedent's	Education	16a. Dece	edent's Usual Occup	ation		16b. Kind of	Business/In	dustry	
Maryland 21215-0036	within 72 iene, than "na the Media	Completed	(Specify only highest	grade completed) College (1-4or 5	+)	e kind of work done of DO NOT use retired Ousewife	during most of wor i)	own home				
andz	d be filed ental Hygi ced other c event, t	Be	17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surr								ζ	
Mary	12 should be f h and Mental h 7 Is marked of traumatic eve	P P	19a. Informant's Name/Relationship			ing Address (Street					,	
	1 and Healt Sm 2		Pamela Kleacas 20a. Method of Disposition	n/guardian	20b. Place of Disp	N. Calver	t St Suit	te 300;	Baltim 20c. Locatio			2
Baitimore,	iges or of		1 Surial 2 Cremation 3		cemetery, cre	ematory or other plac	i i			•		
	t. Pa ntmer tant:		4 □ Donation 3 10 Other (Opt	-		of Faith 22. Name and Addre	6/9/2	2010	Baltim	ore, N	D w Hoid	htc
g	Departiment of the control of the co		21. Signature Euneral Survio Li	waye Dir	ector	State An Baltimor	ss of Facility NOV a tomy Bo	er r.n. ard: 65	5 W Bo	1timo	y neig	nts
	40= 40		14mm/	Mass.						7		
			23a. Part. Enter the disease, or 6 shock or heart failure. List of	omplications that caused nly one cause on each lin	e.		ng, such as cardiad	or respiratory a	arrest,		Approximate Interval Betw Onset and D	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	a.	Sep	513						
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):							
	LXuillilei	Ļ	Sequentially list conditions,	b.								
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Ingary)	Due to (or as	a consequence of):							
oʻ	e executed sian and urial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):									
9/89	ficate be ex physician s the buria	edical	d									
P.O. Box 68760,	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	/			Date of delive Month	-	'ear
J.	that ed by deta		Part II. Other significant condition	s contributing to death bu	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco use c	ontribute to	the cause of de	eath?
dS	uires sign ld be	d by	Morbid	Obesity				1 🗆	Yes 2 No	3 □ Pro	bably 4 🖼 🗗	nknown
Ö	v req beer shou	Completed						24a. Was	200 24	Ib. More sut	opsy findings a	wailablo
ě	ne lav has ge 2	ш			.			auto	opsy formed?	prior to co	ompletion of ca	use of
<u>a</u>	n: Ti ficate rr, pa		OF Western Constitution and Constitution					1□ Yes		1 🗆 Yes	2□ No	
<u>=</u>	Physician: this certificatal director, p	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea		<u> </u>			
ō	Physral di	۲.	1 Yes 2 No 27. Man 1 Death	28a. Date of Inju	nt 2 ER/Outpatie	all S DOA	4 ET Nursing F	lome 5 Res	idence 6 ∐o how injury oc	- ' '	ify)	
0	dlng h. Afte fune	ion	1 A atural 5 ☐ Pending	(Month, Day	Year) Injury	Wor	k? Yes 2⊟No	200, 0000130	. How injury co.	outrou		
Division or Vital Records,	i or Attending after death. Director: After I in by the fune	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be Ose Place of inju	Iry - At home, farm, s c. (Specify)			28f. Location City or To	(Street and Nu own, State)	ımber or Ru	ral Route Numb	ber,
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examination and/or i	investigation, in my o	opinion, death occ	urred at the time	e, date and pla	ce, and due	to the cause(s))
	o the	Me	29b. Signature and title of certifier	^ ^		29c. Licens	e number	1	29d. Date sig	gned (Month	, Day, Year)	
)	⊢ s ⊢ ŏ		Dura 12	-A-	M.D.	200	69314		05	125	12010	
			30. Name and address of person w	pati 8812	eath (Item 23a) (Type Waltha	29c. Licens DOC Print) Woods	Red, Pa	Mert 1	e Mo	211	24	
	Sta Regist		31. Date filed (Month, Day Yee)	1 2010 32. Benjistra	ar's Signature	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:49 A ... Physician/ May 28 Higgins Lauten 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Towson If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 F Months North Carolina 237-76-4375 58 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director be notified Baltimore Lutherville Maryland 1 Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a o U.S.A. 712 Hawkshead Road 21093 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No 1 Never Married 2 X Married ò Specify: White 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Attorney Law 27 is marked other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Doris Higgins John Jacob Lauten, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 712 Hawkshead Road Lutherville, Maryland 21093 Jill Andersen Lauten/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Important: If it any injury or o once,

Physician/ Medical **Examiner**

Physician/Medical

<u>م</u>

Completed

Be

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Certificate:

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Sequentially list conditions if any, leading to immediate

Immediate Cause (Final

disease or condition resulting in death)

☐ Burial 2 🔀 Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

23a. Part 1. Enter the disease, or shock, or heart failure. List of

		ions that caused the death. I luse on each line.	Jo no
_	a	JASTRIC.	C
ſ		Doe to (or as a consequen	ice of
!	D	Due to (or as a consequen	ice of
1	c	Due to for an a consequen	200.05

enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death

22. Name and Address of Facility Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last
IF FEMALE:

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death Unknown

2	Ectopic pregnancy
ى ت	Ectopic pregnancy
5 🗌	Other (specify)

Hilltop Service Corp 5/29/2010

23d. Date of delivery

1 Yes 2 No 9 Unknown	
Part II. Other significant condition	s cont

in the past 12 months?

ributing to death	but not resulting in	the	underlying	cause	given i	n Pa	art 1

1 🗆 Yes 2	No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?

23e. Did tobacco use contribute to the cause of death?

Towson, Maryland

25. Was case referred to medical examiner? 1 Yes 2 No
27 Manner of Death

	1 Inpatient 2 I	ER/Outpatier
28a.	Date of injury (Month, Day, Year)	28b. Time of injury

28e. Place of Injury

building, etc.

R/Outpatient	3 🗆 I	DOA	Other: 4	☐ Nursing F	
28b. Time of injury	М		Injury at work?	2 🗆 No	

Other:

26. Place of Death (Check only one)

k onl	y one)		
ome	5 Residence	6 Other (Specify)	HOSPICE
	Describe how ini		

1 Natural	5 ☐ Pending
2 Accident	Investigation
3 Suicide	6 Could not be
4 Homicide	determined

	M	1 L
- At home, farm, : Spec <i>ify</i>)	street, facto	ry, office

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Numb City or Town, State))e/

(Check only one)	2 ☐ Medical Exa 3 ☐ Certifying N
29b. Signature a	nd title of certifier

uminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. urse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Ī	29c. License number
	264395

MAY 28, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 NCHARLES ST. SUITE 4105 BALTIMORE, MD 21204

Hospita

DOGERMAN, MO

State Registrar

n 24 hours are: we he Funeral Director: Aff

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23°, 2010 May 4:20 AM Marguerite M. Lake 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Baltimore Parkville Oak Crest Care Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. Months 1 □ M 2 🖾 F 91 219-05-6988 Maryland July 12, 1918 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Parkville MD Baltimore 1 □Yes 2 □ No 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 21234 U.S.A. 8800 Walther Blvd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retail Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) UNK 17. Father's Name (First, Middle, Last) John Maier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Mary Jane Lane Bel Air, Maryland 21015 Nelson Dickerson/Nephew 20b. Place of Disposition (Name of Cometery, community or other place) Dulancy Valley Memorial Gardens May 25, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 2010 Exars Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, MD 21234 of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final mouths ASC YD disèase or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 I I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician for use as the buria page 2 s Hospital or Attending Physician: The certificate

sician and burial-trans director, safter deural Director: Afr filled in by 24 hours a Funeral I

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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Be Completed

Certification: To

Medical

r than "natural", or items 23a or 28a-f show

Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, It once.

Pages 1 and 2 should be 1 nent of Health and Mental

permit.

Physician

Examiner

/Medical

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Baltimore, Maryland 21215-0036

		seizur O					24a. Was an autopsy findings a prior to completion of ca death? 1 □ Yes 2 □ Ne 1 □ Yes 2 □ No	vailable use of
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No		26. Place of Death (Check only one)						
		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Jursing Ho					lome 5 ☐ Residence 6 ☐ Other (Specify)	
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c	. Injury at Work? 1 □Yes	•	28d. Describe how injury occurred	
	6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number of Town, State)	er,	

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

MD# R067343

Name and address of person who ompleted cause of death (Item 23a) (Type, Print) Walther BIVd. PARKVILLE, MD. 21234

and manner stated

BRA 31. Date filed (Month, Day,

State Registrar

completely

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05-28-2010 **Physician** Adele Lenora Miller 0700 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Year) 11-13-1933 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 👿 F Months Days Hours Min 76 MD Director 213-32-3239 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shorthe Medical Examinar must be notified at Director 1 ☐ Yes 2 🙀 No PA n/a Red Lion 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 178 Winners Circle Drive 17356 Funeral **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 💢 No 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🏋 No ģ Specify White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Clerical 7 Is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry H. Watts MaryJane E. Galway ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Is permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr once. Stephen Miller (Son) 214 Jenny Lane Stewartstown PA 17363 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cem. 06-01-2010 | Baltimore, MD 4☐Donation 5 ☐Other (Specify)Entombment 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Renal Insuffe disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner 9 bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Duscase physician and s the burial-trans End stage LIVER Due to (or as a consequence of): Milke Adele Mgoo47174 (Division of Vital Records, P.O. Box 6876) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 ☐ Yes 2 🔀 No 1 ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🗖 Natural To the Hospital or Attendiwithin 24 hours after death.
To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00067452 MD 28 JOKSIM

State Registrar

500 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAJAHATH MOHSINI

BUR AIK

21014

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upper chesipula ion

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg.,No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 05-27-2010 Year Physician/ Francis X. Meadowcroft 0445 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth Birthplace (State or Foreign Country)
 MTD 6. Sex. 1 Å M 2 ☐ F **Funeral** Months Hours Min 05Mo215 Day 9990 80 213-26-5748 Yrs Director Usual Residence of Deceden ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 ☐ Yes 2X No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 902 Shelburne Rd 21015 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black. White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. life. DO NOT use retired) Elementary/Seconday (0-12) College_(1-4 or 5+) Attorney General Practitioner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Robert Meadowcroft Mildred Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Meadowcroft (Wife) 902 Shelburne Rd Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gar: 06-01-2010 Bel Air, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licenses Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Gram Positive Sequentially list conditions, if any, leading to immediate couce. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the 9 Unknown PO signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 slag 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? nlis 24a Was an cate has page 2 s autopsy performed; certificate 1 Yes 2 No 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᅙ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15/5/NL MD 00067452 27/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ppu ches speake or BURAIR 21014 500 LEYZKOM, HTIAHATAW 31. Date filed (Montal to egistrar's Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 5:00 PM 2010 2 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Sykesville Fairhaven 9. Birthplace (State or Foreign Country)

NY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 □XF 103 Director 1906 066-18-6622 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r than "naturai", or items 23a or 28a-f shov the Medical Examiner must be notified at Sykesville 1 Yes 2 No MD Carrol1 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA HC 114 7200 Third Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ No Specify: 2 3 ☐Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2^{College (1-4or 5+)} I Hygiene. Elementary/Secondary (0-12) domestic homemaker permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien. Important: if Item 27 is marked other the any injury or other traumatin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leila Tanner Samuel H. Potter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 273, Glenwood, MD 21738 19a. Informant's Name/Relationship (Type. Print) Nancy Mason Szlasa (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 Removal from State 6-4-10 Oneonta, NY Glenwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dauge Haught Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ementia Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 in the past 12 months Month Day Year 4□Pregnant at time of death 5 Other (specify) Yes 2 Q NG Records, P.O. the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1∐ Yes 2 No Division or Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA P After this funeral dir 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours are death To the Funeral Director completely filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) Sykesville M.D. 7200 Third AVELUE, Thomas Vento, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 30 FRANCES MARIAN RUARK MEARA 2010 11:05 A™ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HEART HOME, LUTHERVILLE Baltimore County Lutherville 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan 17 **Funeral** Days 1 □ M 2 💢 F Months Hours Yrs. 219-18-6130 86 Director Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important, If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified ** once. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No Maryland Baltimore County Lutherville 10e, Street and Numbe 10g. Citizen of What Country? Funeral 21093 1414 Front Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates, 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Balto, City Public Elementary/Seconday (0-12) College (1-4 or 5+) Schools Science Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Warren Frances Slack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) F. Amy Macko (Daughter) 2422 Briarwood Avenue, Baltimore, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 6/1/2010 Baltimore, Maryland MITCHELL BOOK Baltimore, Maryland 21212 21. Sign / of Fundral Service (Laryson Laryson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COMPLICATIONS OF disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a nonsequence on if any leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Yes 2 No the g 🗌 Unknown signed by to be tach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) #55570 UVING After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No iniury 1 Natural 5 Pending 2 Accident Investigation after death

Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N CHARLES ST, SMITE 4105 BALTIMITE, MS 21204 DANIEHE DOBERMAN, MD 31. Date filed (Month, Day, Year) 32. **R**egi rar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registrar Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2010 8:45 P M May Physician/ Marshall Margaret Ι. Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Bethesda 4709 River Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Washington, D.C. Days Hours Min. (Month. **Funeral** Months 1 □ M 2 🛛 F August 84 218-20-0292 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 No Bethesda Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral United States 20816 4709 River Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 1 Never Married 2 Married Hygiene. 1 ☐ Yes 2X No Specify: Specify: Baltimore, Maryland 21215-0036 White If Yes Give 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Administrative Officer 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Christina Eckhardt ည <u>John L. Imirie</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4709 River Road, Bethesda, Maryland 20816 Mildred H. Imirie/Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 1,2010 Suitland, Maryland Cedar Hill Cemetery Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Signature of Funeral Service Licensee 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dysphagia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pick's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Year Month Day in the past 12 months? Pregnant at time of death Yes 2 X No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical filled in by the funeral director, Be examiner?

1 X Yes Other: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I DOA 2 No Certificate: To 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death work?
1 \(\sum \) Yes 2 \(\sum \) No injury 1 X Natural 5 Pending M after death. Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 4 Homicide determined within 24 hours a

To the Funeral D

completed filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tid of certi May 24, 2010 D35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 Registrar

State

M.D.

32. Regit dans Signature

Susan J., Miller,

31. Date filed (Month, Day,

8218 Wisconsin Avenue #305, Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Joseph Clay Madison 2010 May 28 9:17 A. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore County 9 Glendorian Court Hunt Valley 5. Social Security Number 239-82-955 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Nov. 03, 1955 **Funeral** 7. Age (In yrs. last birthday) 1 **™** M 2 □ F Min 54 Director Roanoke, VA Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 1 No Maryland Baltimore County Hunt Valley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Glendorian Court 21030 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) N/A Elementary/Seconday (0-12) Computer Analyist Computers 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Everette Owen Madison Mary Alice Sowder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 24018-8021 Mr. Richard L. Madison(Brother) 5533 Country Lane Roanoke, Virginia Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel and 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State (Harford County) May 31,2010 4 Donation 5 Other (Specify) Forest Hill, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral & Commation Center, P.A. 21. Signature Jeffrey L. Gair, Sr. Timonium, Maryland 2325 York Road Part 1. Integrate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Vascular disease Atherosclerosis Physician/ disease or condition REWS Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami and -transit that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year ed by the a 9 Unknown P.O. been signed k should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 X No Medreations death? the Funeral Director: After this certificate Inpleted filled in by the funeral director, pag 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{\text{Nursing Home}}\) Nursing Home 5 \(\text{\text{Mesidence}}\) Residence 6 \(\text{\text{\text{Other}}}\) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 Yes 2 No 5 Pending after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Brent & Mardonald, mp Physician 247205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beltimore, up 21236 Brent B. Macdonald mp , Suite 200 4924 Campbell Bovievand 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret F. Nikola May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Min. 1 □ M 2 💢 F Hours (Month, Day, 1) Director 140-16-1703 88 Dec. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Director must be notified MD Baltimore Cockeysville 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 10 Pickburn Ct. 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner ò þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 Yes 21 No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: white Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clinical Social Worker Be 17. Father's Name (First, Middle, Last) and Mental Fis marked o ၉ Harry O'Connor permit. Page 1 and 2 should be Department of Health and Ment Important: If Item 27 is marke any injury or other traumatic once. Elizabeth 19a. Informant's Name/Relationship (Type, Print) Carol Marie Nikola/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 5/29/10 MD Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens 21. Signature of Funera Michael 3 23a. Part 1. Entire the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ failure Renal disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner pertusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown detached Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Completed 24a. Was an page 2 s has autopsy certificate Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending injury Accident 1 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 23 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier RNA R149194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Challs Grah

Balto. County 18. Mother's Name (First, Middle, Maiden Surname) maiden name (unknown by informant) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1652\ Devers\ Rd.,\ York,\ PA\ 17404$ 20c. Location - City or Town, State Timonium, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10W. Padonia Rd., Timonium, MD 21093 Approximate Interval Between Onset and Death 23d. Date of delivery Dav Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Nother (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, 29d. Date signed (Month, Day, Year) 25,2010 May MD 21204 32. Regiarár's Signature

2010 Year

<u>3:5</u>5 P^M

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 X No

NJ

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day; Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Month Mamie Alice Narvell May 23 10:35 A.[™] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Dec. 23 ^{Year} 1930 Pennsylvania 79 **Director** 187-24-0807 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Harford 1 Yes 2 No Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1525 Sunshine Drive 21154 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural", 3 Widowed 4 Divorced id Mental Hygiene.
marked other than "natur
matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Press Operator Rubber Products æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Herman Few Kathryn Pickel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Larry Thompson / Son 1538 Galaxy Drive Street, Maryland 21154 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite any injury or ot Evans Funeral th Chapel 1 Burial 2 X Cremation 3 Removal from State 4 Donatjon 5 Other (Specify) 2010 Air Forest Hill. <u>Maryland</u> 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-BelAir 3 Newbort Drive Forest Hill, Maryland 21050 uneral Service bicenses 21. Signatur 23a. Part 1. Enter the disease, or compl ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final inset and Death Ph sician/ disease or condition resulting in death) END STAGE CHRONIC OBSTRUCTIVE PULMONARY EARS Medical Due to (or as a consequence of) Examiner DAY 5 SCITERICITIA COLI URIVARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 s autopsy performed Yes 2 Hospital or Attending Physician: The Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Tes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident injury work? 5 Pending 2 🗆 No Investigation 24 hours after deat Funeral Director: completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the within To the 29b. Signatu 29c. License number ed cause of death (Item 23a) (Type, Print) and address of pe MN 21078 anska 49 31. Date filed (Month, Day, 32. Redistrars Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. OCONNELL 2010 1340 PM MAURICE JOSEPH Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death North Arundel Rehabilitation Center Glen Burnie Anne Arundel 5. Social Security Number 6. Sex 1 Å M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 215-22-5165 12/22/1926 83 Yrs MARYLAND **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Pasadena Anne Arundel 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21122 8230 Meadow Wick Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. White Completed 3 ₩ Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lockheed Martin Boiler Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Maurice O'Connell Mary Flynn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8230 Meadow Wick Court, Pasadena, Maryland 21122 19a. Informant's Name/Relationship (Type, Print) Mr. Michael O'Connell / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State May Glen Burnie, MARYLAND Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation MO1580 2nd Ave.SW Glen Burnie, MD 21061 Services PA 1 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death MYOCARDIAL Physician/ ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine TRICULAR SEPTA Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by KIDNEY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No Yes 2 N 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} Other: 2 🔀 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🖪 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) within 24 hours after deau.

To the Funeral Director: After this commieted filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Phanu D0058580 2010

State Registrar

9x1

BOWIE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUPERIOR

Kanu MD. 3233

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY PRESLE MARGARET 10:25 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BANTEN MEDICAL CENTER BALTIMORE JOHNS HOPKENS If Under 24 Hrs. 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Country) MD 1 □ M 2**X** F Months Days Min (Month, Day, Year) Hours 216-30-5889 76 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21224 7264 Gough Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify:White Completed 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rosalie Crowe Ralph DiCredico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7750 Wynbrook Road, Baltimore, MD 21224 Daniel Presley - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Commation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Bayview Crematory 6-2-10 Baltimore, MD 21. Signature of Funeral Ser 22. Name and Address of Facility Bradley-Ashton Funeral Home 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chysician/ FATLURIS HEART CONGESTIVE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or imjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No Hospital 1 🗌 Yes မှ 1 Pinpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending n 24 hours after death.

he Funeral Director: After the funeral parts of Accident work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Bev 7/2009

Registrar

4940 EASTERN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O.M

MARC LAROCHELLE 31. Date filed (Month, Day, Year)

RES-000

BALTEMORE

AVENUE

MAY

21224

MD

31,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State Registrar	State of Maryla		artment of H tificate of D			giene Reg. No. 201	0 16799
	Physicia		1. Decedent's Name (First, Middle, Last) MAPU F OF T	74				2. Date of De Month	ath	3. Time of Death 6:45am
	Medic Examin		4a. Facility Name (if not institution, give stre HART HERITAL	eet and number) 3E ESTA	T E	4b. City, Town, or	Location of Deatl	<u> </u>	4c. County of De	
	Funeral Director		5. Social Security Number 6. Sex	M 2 F 7. Age (in yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	v Year) C	irthplace (State or Foreign Nountry) Maryland
- 2	3	ř	Usual Residence of Decedent 10a. State 10b. County	0	ity, Town or Loc	eation		1 2/1	736	10d. Inside City Limits
	Marylar 28a-f sh otified	irecto	Maryland Harford		treet					1 ☐ Yes 2X No
	with the s 23a or ust be n	Funeral Director	10e. Street and Number 1262 Trappe Road			10f. Zip Code 21154			10g. Citizen of What C	Country?
36	after death al", or items Examiner mi	by		. Was Decedent Ever in U Armed Forces? 1 Yes 2X No If Yes, Give	11	Vas Decedent of Hi Yes, specify Cubar	n, Mexican, Puert		14. Race - Am Black, Wh Specify: Wh	ite, etc.
21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ice event, the Medical Examiner must be notified at	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Seconday (0-12)		(Give I life. Do	lent's Usual Occupa kind of work done d O NOT use retired)		king	16b. Kind of Busines Own Hom	s Industry
and Z	oe filed wit ental Hygie ced other c event, th	To Be C	9 17. Father's Name (First, Middle, Last) Roy Amos Smithson		Hom	emaker		me (First, Middle, ane Webb	Maiden Surname)	е
Maryland	should and M is mar		19a. Informant's Name/Relationship (Type,		1	-	and Number or Ru	ral Route Numbe	r, City or Town, State, 2	
	and Healt		Ronald C. Petty /	20h	Place of Dispo	sition (Name of	T T	avre de	Grace, Mar 20c. Location - City	yland 21078 or Town, State
Baltimore,	permit. Page 1 Department of Important: If it any injury or o	C	1 XBurial 2 Cremation 3 Re	moval from State Net Bar	otist C	natory or other place e hurch Cer	n. : 5/3	1/2010		un, Maryland
Ra	Depa Impo any i		21. S. na ne di runera/Service Licensee	naston	+	. Name and Addres			Funeral Ho Maryland 2	
-	Ph _y sician/		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one of Immediate Cause (Final disease or condition	cause on each line.)	Penson 1		or respiratory an	rest,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					
	cuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	Due to (or as a consec						
09	certificate be executed inding physician and use as the burial-transit	edical E	resulting in death) Last	Due to (or as a consec	quence of):					
. Box 68/	certific inding use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant and in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	i. If yes, outcome of pregn 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	taí death 3 🗌	Ectopic pregnanc Other (specify)	у		23d. Date of c Month	delivery Day Year
ds, P.O.	The law requires that the death ate has been signed by the atter page 2 should be detached for	by	Part II. Other significant conditions contri	ibuting to death but not re	sulting in the u	nderlying cause giv	en in Part I.		obacco use contribute Yes 2 \(\square\) No 3 \(\square\)	to the cause of death? Probably 4 \square Unknown
Division of Vital Records,	The law rec ate has bee page 2 sho	Completed						24a. Was autop perfo 1 Yes	prior to rmed? death	autopsy findings available o completion of cause of es 2 \(\text{No} \)
Vital	ysician: s certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hos	spital:	FR/Outpatier	_ Othe	er:		dence 6 Sther (Spe	ASSISKED
n of	ding Phy h. After thi funeral o		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at		ow injury occurred	outy) — s
JIVISIO	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director After this certification place of the funeral director, completed filled in by the funeral director,	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif			ies 2 🗀 NO	28f. Location (S City or Tow	Street and Number or F rn, State)	Bural Route Number,
	e Hospit 24 hour e Funere leted fille	Medical	(Check 2 Medical Examiner	an: To the best of my know : On the basis of examination ractioner: To the best of m	on and/or invest	igation, in my opinio	n, death occurred	at the time, date a	ind place, and due to the	e cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	Tadament to the best of the	ny knowledge, c	29c. License	number	5	29d. Date signed (Mor	oth, Day, Year)
			30. Name and address of person who com	pleted cause of death (Itel	m 23a) (Type, F	rint)	1188	S. 1 0 :	40 2:	(1)
	Sta	e	29b. Signature and title of certifier 30. Name and address of person who compact filed (Month, Day, Year)	22. Registrar's Sign	ature A	barre	tpel /	JE NIN	100 410	17
	Registra	ar	I RINULA	LUIU NOW	10.					

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 27, Physician/ 9:30 P Carolyn L. Platt 2010 May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Springhouse of Westwood Montgomery Bethesda 5. Social Security Number 8. Date of Birth (Month, Day, Y August 22 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Florida 022-20-5275 Yrs Director 84 1925 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature?" any injury or other traumatic events. 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 K No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 5101 Ridgefield Road 20816 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🙀 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0wner Antique Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ James Lindner Selma Turin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurence E. Platt/Son 4411 Stanford Street, Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Philadelphia Memorial Park 2010 Frazer, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. 21. Signature of Funeral Service Licensee Pumphrey Funeral Home/ Bethesda-Chevy Bethesda, Mary1 Chase 208 Inc. 7557 Wisconsin Avenue M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Atherosclerotic Heart Disease Medical Due to (or as a consequence of) Examiner Hypothyroid Sequentially list conditions, Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Anemia physician and the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Renal Insufficiency Division of Vital Records, P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death signed by the a Yes 2 X No g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Osteoporosis 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Arthritis 24a, Was an Jas autopsy 2 No Yes 2 🔯 No 1 Yes 26. Place of Death (Check only one) completed filled in by the funeral director, 25. Was case referred to medica Be Hospital: Other: 2 X No 1 🗌 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 🔀 Nursing Home 5 🗌 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🖾 Natural injury work? 1 ☐ Yes 5 Pending 2 🗌 No М Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medica 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the certifie 29c. License number 29d. Date signed (Month, Day, Year) D53691 May 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 3200 Tower Oaks Blvd., Rockville, Maryland 20852 Ajay Reddy, 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 28, 2010 5:20 A Physician/ Caroline Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Year 941 **Funeral** Mary land Days Hours Min. 1 🗆 M 2 🙀 F 68 219-38-9023 Director Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10b. County 10a, State Director 1 Yes 2 No Rosedale Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21237 291 Attenborough Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No within 72 hours after death 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Specify: White 1 ☐ Yes 2 🔀 No Specify: Baltimore, Maryland 21215-0036 If Yes Give 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) and Mental Hygiene. is marked other than College (1-4 or 5+) G.B.M.C. Patient Coordinator 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ၉ Helen Mazanek Peet Charles 1 and 2 should b f Health and Mer item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 291 Attenborough Drive Rosedale, Md. 21237 Ε. Pfeiler / Husband Paul or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or oth Page 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 5/29/2010 Towson, Maryland Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) 1050 York Road 22. Name and Address of Facility permit. 21. Signature of Funeral Service Licens Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cardie on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OVARIAN ANCE Months Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Year Month Day in the past 12 months?
1 Yes 2 ANo g Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Hospital 4 Nursing Home 5 Residence 6 ther (Specify) 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at 27. Manner of Deat 1 Natural
2 Accident
3 Suicide
4 Homicide work?
1 Yes 2 No 5 Pending M Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUN 31. Date filed (Month, Day, Year)

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State

Registrar

32. Registrar

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 3PM 77 Medical not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Age (In yrs. last birthday) If Under 2 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Hours Min. Month, Day, July 29. 34 Director 403-04-1150 Kentucky Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

any injury or other trans. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 850 E. Wheel Road 21015 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Food Service Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bearclaw Phyllis Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Phyllis Simmons (Mother) 850 E. Wheel Road, Bel Air, Maryland 21015 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 28, Evars Funeration Patterplace)
Bel - Air Forest Hill, Maryland 4 Donation 5 Other (Specify) 2010 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Bel Air
3 Newport Drive, Forest Hill, Manyland 21050 21. Signature of Funeral Service Licenses 23a. Part 11 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to r as a consequence of) Examine chest abdoman extremities Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of MEDICAL EXIM Physician/Medical P.O. Box 68760 CERTIFICATION APPROVED IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Yes g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an After this certificate has autopsy performe the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ျ 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1, Natural 2 Accident 3 Suicide 5 Pending work? motor vehic Investigation 24 hours after death 6 Could not be e. Place of Injury - At home, farm, street, factory, office building etc. (Specify). 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined Riests + Herdenson Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b., Signature and title of certifi-29c. License number 29d Date signed (Month, Day, Year)

State Registrar person who

32. Regis

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tem 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 24 2010 12:15pm [™] Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1300 Driver Road Marriottsville Howard 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jan. 14, 1932 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 D F Min. Hours Director 219-28-1493 Yrs. Jän. 78 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 V No MD Howard <u>Marriottsville</u> ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 1300 Driver Road 21104 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 XMarried Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify. White 1951-55 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene, marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Electrical Contractor Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Wilbert Reedy Mary Price McKenzie permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumaria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 Driver Road Marriottsville, MD 21104 Mrs. June L. Reedy (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 5/25/2010 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, P.A. 21. Signature of Funeral Service Licenses Haw 100764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition YPAR Medical resulting in death) Examiner Sequentially list conditions, if ny cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine DIRE to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and ested filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 2 🗌 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, neumonia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after
To the Funeral Dire
completed filled in b City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed ca use of death (Item 23a) (Type, Print) Ø 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mav Roddy 2010° Rosalvn 4:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Owings Mills</u> 4700 Coyle Road Baltimore Apt. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗐 F Country) 9717271932 Director 77 PA 215-30-8607A Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2xx No Owings Mills Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? Funeral 4700 Coyle Road 21117 United States Apt. 101 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian 0.0 1 ☐ Yes 2**XX**No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural" 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Her Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Lawrence Rayboen other traumatic Fanny Kahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Shawn Costello Whooley/Daughter 1 Prettyboy Garth, Parkton MD 21120 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) any injury or 1 Burial 2XXCremation 3 Removal from State 4 Dopetion 5 Other (Specify) Carroll Crematory 5/28/2010 Winfield, MD 21. Signature o Funeral Service Licen e Burrier-Queen Funeral Home & Crematory, P.A. W. Old Liberty Rd., Winfield, Part 1. Inter the disease, or complication hock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Imm-diate Cause (Final dis-ase or ondition Physician/ se or onaille ing death) Medical Iting Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a prinsequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 | Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 / No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform death? certificate 2 No 1 Yes Yes 25. Was case referred t dedical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? Natural 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 🗆 29d. Date signed (Month, Day, Year) eath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's State

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3.38 P M Physician/ May 2010 Medical Name (if not institution, give stre Examiner 4b. City, Town, or Location of Death 4c. County of Death (2/es ledice Du Social Security Number 7. Age (In vrs. last birthday If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 XX Months Hours Min. 12/10974949 Mar Tand 90 212-18-7377 **Director** Usual Residence of Decedent if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2**X**(X) No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 113 Riggs Avenue 21146 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married Completed by Yes Baltimore, Maryland 21215-0036 1 Yes XX No Specify If Yes, Give 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Personel Director Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျှ August C R Rodgers Helen R Plack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Bosley Avenue Towson Maryland 21204 Louise Y Meledin Attorney 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of I
Important: If ite
any injury or ot XX Jurial 2 Cremation 3 Removal from State Holy Rosary Cemetery 06/02/2010 Baltimore, Maryland Donation 5 Cher (Specify) nature of Funeral Servi 6500 York Road Baltimore, Maryland 21212 Part 1. Enter the disease, o complications shock, or heart failure. List only one cause 23a. Part 1. Enter the disease, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, Examine il any, leading to intracella cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events s been signed by the attending physician and should be detached for use as the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed After this certificate has within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 1 🗌 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 2 🗌 No 2 Accident 3 Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Glen Burnie

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nelson Randell Reichard 2010 3:45 P. May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1**X**XM 2 □ F Hours Days Balt. Maryland 218-18-5180 84 Yrs. october 22 **Director** Usual Residence of Decedent 28a-f shov with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore Maryland Baltimore 1 Yes 2XXNo 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Sountry?es "natural", or items 23a Funeral 21239 6920 Donachie Road of America permit. Page 1 and 2 should be filled within 72 hours after death v Department of Health and Mental Hygiene. Important if item 27 is marked other than "man any injury or other than "man any injury or other than "man and injury or other than "man and injury or other than "man and injury or other than "man and injury or other than "man and injury or other than "man and injury or other than "man and injury or other than "man and injury or other than "man and injury or other than "man and injury or other than "man and injury or other than "man and injury or other than "man and injury or other than "man and injury or other than and injury or o 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married þ white If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **CPA** Accounting 12 Be 18. Mother's Name (First, Middle, Maiden Surname)

Mable Little 17. Father's Name (First, Middle, Last) ဂ္ Allen Reichard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson R. Reichard, Jr./ son Casco, Maine 04015 P.O. Box 252 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 26, Evants, Function of the place, 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) 2010 Bel Air . Signature of Furferal Service Licen Peaceful Alternatives Funeral and Cremation, Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ solratur disease or condition INTER Medical resulting in death) Examiner idiopathic Sequentially list conditions If any leading to immediate cause. Enter Underlying Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OPS-MUCHWE 1 Yes 2 No 3 RProbably 4 Unknown cate has been sig ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? myelo dys platic Pancy topenia this certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) WOSOL G : After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 🗌 No 2 ☐ Accident 3 ☐ Suicide within 24 hours after death

To the Funeral Director: A

completed filled in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check and title of certifier

State
Registrar

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 14A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. Coupty of Death If Unde 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral X**M 2 □ F Months Hours Min Yrs. Director or 28a-f show filed within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits event, the Me lical Examiner must be notified at Director 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 6 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. "natural", White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working ABF permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me Jones. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City 19028 (SYCN) STORC Rd - U) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) .3 Removal from State cemetery, crematory or other place) /29 hture of Fun ral Dervice Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between O set and Death Immediate Cause (Final Physician/ unsons disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy After this certificate has 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 4 Nursing Home Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 5 Pending injury death. 1 Yes 2 No Accident Investigation completed filled in by the within 24 hours after deal To the Funeral Director: 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Deduction Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) R125973 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . CHARLES ST. 101 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Harry E. Singleto	·	Ir. State of Maryland / Department of H 1-For State Certificate of D. Registrar			, No. 20	10 680
Physicia Medical Examii	ın/	1. Decedent's Name (First, Middle,Last) Harry E. Singleton, Jr.		2. Date of Death	Day Year	3. Time of Death 1248 hrs
		4a. Facility Name (if not institution, give street and number) 4b. (City, Town, or Location of Death		4c. County of De.	ath
Funeral Director			f Under 1 Year If Under 24Hrs. Wonths Days Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. For	Birthplace (State or eign Count
th the Maryland 23a or 28a-f show any notified at once.	I Director	1184 Nochaway Drive	0f. Zip Code 32092		g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	1 Never Married 2 Married Armed Forces? If Yes, s 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto s 2 No specify: Jsual Occupation (Give kind of w	Rican, etc.)	White, etc.	nite
5-0036 ed within 72 hoi lygiene. other than "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade NA Auto W 17. Father's Name (First, Middle, Last)	of working life. DO NOT use retired on the second of the s		Chrysle: Automot:	
21215 nould be file d Mental H is marked tic event, t	æ	MITE	Mildred dress (Street and Number or R	ural Route Numb		
Baltimore, MD 21215-0036 oernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than nijury or other transmatte event, the Medical		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: Other Specify:	ematory 05-			ne, Fl. or Town, State Ville, MD
Balt permit Depart Impor injury		Summerla long 638	N. Gilmor S	Street		re,MD 2121
Physician Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):	tode of dying, such as cardiac or	respiratory arres	t, snock, or neart	Approximate Interval Between Onset and Death
d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):				
5, be execu sician and	edical	UNPENDED AMENDED 28c & d, 29d, pe	er ME g904 6/1/	10 TT		_
Box 6876(e death certificate the attending phys ed for use as the b		25. If yes, decedent pregnant in the past 12 months?			23d. Date of delive Month	ery Day Year
P.O.	Completed by PI	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	1 Yes 24a. Was an autopsy	2 No 3 Pr	autopsy findings available o completion of cause of
Vital Records ysician: The law requi	ادہ	25. Was case referred to medical	26.Place of Death (Check o	performed 1 Yes 2 nly one)		Yes 2 No
n of Vita ding Physici 1. After this co funeral direc	on: To B	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death Natural 5 Pending May 25, 2010 1 1 1 1 1 2 2 3 1 2 3 2 3 3 3 3 3 3 3 3			esidence 6 0 Oth w injury occurred notorcycle	
Divisior spiral or Attend ours after death teral Director: filled in by the	Certification:	2 X Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Road / Highway	actory, office building, etc.	or Town, Stat	eet and Number or F	Rural Route Number, City ty Foot Rd, Parsonsbur
Divis To the Hospital or A within 24 hours after To the Funeral Dire	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a one) 2 Medical Examiner: On the basis of examination and/or investigation, i and mahner stated.	in my opinion, death occurred at			
		29b. Signature and this of certifier (Color Valle Certifier)	29c. License number O.C.M.E.	2	29d. Date signed (M	lonth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, M				
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	le)			

DHMH 17 Rev 1/2001 OCME 2006

27,289-9,290

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date Month Sloan **Physician** INDE 21:14PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country)
 NY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10-05-1953 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🗆 M 2 💢 F 56 081-46-0118 **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Directo Harford the Medical Examiner must be notified MD Bel Air 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ŏ items 23a 2206 Woodstove Ct 21015 IISA Funeral Was Decedent Ever in U.S. Armed Forces?
 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Secretary Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. Esposito Wanda Przybyszewski 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trai James Sloan (husband) 2206 Woodstove Ct Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Highview Mem. Gar. 05-29-2010 Fallston, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee 00 Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Uccaus or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 5 Other (specify) the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed 2 of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Physician: Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ this completely filled in by the funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending After 1 Natural 2 Accident (Month, Day 5 Pending investigation Injury death. 1 Tyes Director: 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only

the within To the

DHMH 17 Rev 1/2001

State

Registrar

one)

29b. Signature and title of certifier

GABILIE

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

RES- 000

010

600 North Wolfe St, Baltimore, MD, 21287

Box 68760

Records,

Division of Vital

Division of Vital Records, P.O. Box 68760,

3. Time of Death Year 13.35PM 2010 4c. County of Death Baltimore Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian White 16b. Kind of Business/Industry Chemical Company 18. Mother's Name (First, Middle, Maiden Surname) (unavailable) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5973 Setter Drive, Elkridge, Maryland 21075 20c. Location - City or Town, State Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMI., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown v24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes filled in by the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To m. 28d. Describe how injury occurred Hospital or Attending I hours after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M) 285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 203, m) 32. Registrar's Signature Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

1 - For State Registrar 1. Decedent's Na

Director

Completed by Funeral

Be

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Examine

Physician/Medical

Completed by

Certificate: To Be

Medical

29a. Certifier (Check only one) 29b. Signature and title

31. Date filed (Month, Day, Year)

Physician/

Medical

Examiner

Funeral Director

State Registrar						tificate	of Dea		Mental Hyg F	leg. No.	2010	1681
Decedent's Name	e (First, Middle	e, Last)							2. Date of Dear	th		3. Time of Death
EDWARD J.	STRILE	Υ							Month MAY	25	Year 2010	5:00 P M
Facility Name (if I	not institution	, give street and nun	nber)			4b. City, To	own, or Loca	ation of Death		4c. Cou	inty of Death	
203 B COU		LOTHI					ARUNDE					
Social Security Nu 203 22 718	In yrs. last bii 80	thday) Yrs.	If Under 1 Months		urs Min.	8. Date of Birth	^Y 1930	9. Birth Cou	nplace (State or Foreign ntn p)			
ual Residence of I												
. State	10b. County		1	10c. City, Tow	n or Loc	cation						10d. Inside City Limits
MD		ARUNDEL		LOTHIAN								1 Tes 2 XXNo
. Street and Num	nber					10f. Zip C	Code			10g. Citizen	of What Cou	intry?
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Marital Status 1 Never Marrie	ied 2XX	12. Was Dece Ayoged Fo	orces?		1f	Yes, specify	y Cuban, Me	exican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White,	
3 Widowed 4		If Van Cir			1	☐ Yes 💆	No Sp	ecify:		Spec	cify: WHI	ITE _
(Cno.		nt's Education		168		lent's Usual (16b. Kind o	f Business Ir	
Elementary/Seco		est grade completed College (1				O NOT use re		most of work	ing			
12					M/	AINTENA						OVERNMENT
Father's Name (F	First, Middle, L	_ast)					18.	Mother's Nam	ne (First, Middle, M		ame)	
ık	(D to:								HAL			
a. Informant's Na		nip (<i>Typ</i> e, <i>Pnnt)</i>	70			1000000			al Route Number,		n, State, Zip	Code)
. Method of Disp			WIE			rd AVE. sition (Name			E, MD 2106		on - City or T	Town State
1 ☐ Burial 2 X	X Cremation	3 Removal from	n State	cemete	ery, crem	natory or other	er place)		Date		on - City or T	
4 Donation Signature of Fun		Specify)	\triangle	BAYVHEW	CRE							
	naval Camina l	· Zanad	\rightarrow	\rightarrow				5.26		BALTIM	ORE, MO)
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K GREG	ORY FIN	complications that	caused th	M01148	22 F1 42	INK FUNI 26 CRAII	ÉRÁCS AC N HWY S	ME P.A.	BURNIE, MD	21061	IORE, ML	
K GREG	ORY FIN he disease, or it failure list of	1	caused thach line.		22 F1 42	INK FUNI 26 CRAII	ERAL SHOOT OF DESIGNATION OF DESIGNA	ME P.A.	BURNIE, MD	21061	IORE, ML	Approximate Interval Between Onset and Death
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1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

063726

29d. Date signed (Month, Day, Year)

Burne

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mondone

0105

29c. License number

State

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAJECODY WILL 1406 South Crain Hayhne, Chin Brind

strar s Signature

32. Re

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** May John D. Stefanski 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Franklin Square Hospital
5. Social Security Number 6. Sex 17. A Kosedale Year | If Under 24 Hrs. | Center baltimore If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□ F Months Days Hours Min. 219-60-2928 **Director** 3-25-1955 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h Count show Department of Health and Mental Hygiene. Important: if item 22 is no 28s4 show amortant: if item 27 is marked other than "natural", or items 23s or 28s4 show amortant: if item 27 is any injury or other traumatic event, the "Necical Examinar must be notified at once. Director 1 Tyes 2 Two MD Baltimore Baltimore 10e. Street and Number 10f Zip Code 10g Citizen of What Country? 437 Kosoak Road Funeral 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 MNo If Yes, Gîve Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Bethlehem_Steel Crain Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Daniel Stefanski Rose Gunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 Stefanie Stefanski-Daughter 2909 St. Paul St., Apt.#3, Balto., MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 6-2-2010 | Baltimore, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home DiHOKK llow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancel Non Small cell /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physiclan for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No the 9 I Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Pulmonary Embolism 1 Yes 2 No 3 Probably 4 Unknown peen Deep Venous Thombosis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy The certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check onl one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this c Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

Stefanski,

9000 Franklin Square Prive, Baltimore Mu 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wooten

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Shamilova Day Year Alya 2:55 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE@NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 **X** F Min. 83 1071271926 SOUTET UNION 213-37-0642 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD N/A BALTIMORE 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funera 1 RUSSERN COURT, #1C 21215 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Tes 2 X No Specify. WHITE Completed 3 X Widowed 4 □ Divorced Specify. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. 2 ILYA **OSEPOVA** SARAH UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 85 FENNINGTON CIRCLE, OWINGS MILLS, MD 21117 KHANA GAVRILOVA/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State IBERTY CPARKY OF O'EER PLACE)
SHAAREI ZION CEM. 4 Donation 5 Other (Specify) 05/28/2010 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD, PIKESVILLE, 21. Signature of Funeral Service Licens INC. MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death (Cardiovascular accident Physician/ End. Stay CVA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, Lading to immediate cause. Enter Underlying by Physician/Medical Examine Due to or as a conse quence of burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has performed After this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other:
4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) nský apahamo

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

S. Rajapakse, MID

D0057465

2835 Smith AV 5235 - Bultimore, MD. 21209

5 127/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rebecca Shorts May 2010 9:00 P M Loretta Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Himalayan Elderly Care Montgomery 9. Birthplace (State or Foreign Country) Maryland . Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Hours February 10, 1944 1 □ M 2 🛛 F 216-40-7420 66 **Director** Usual Residence of Decedent or 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 1909 Alabaster Drive 20904 United States death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married ð 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic access. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Elgar Evelyn Rebecca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Willett / Niece 4828 Marsden Court, Frederick, Maryland 21703 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Parklawn Memorial Park 2010 Rockville, Maryland 4 Donation 5 Other (Specify) Signature of Fune a Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
Six Weeks Immediate Cause (Final Physician/ Metastatic Ovarian Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ه ا 2 No 3 Probably 4 H Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 K Nursing Home 5 Residence 6 Other (Specify) 2 💢 No 2 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending injury 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D22309 May 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9013 Flower Avenue, MDSilver Spring, Maryland 20901 Philip Poth, 31. Date filed (Month, Day, Year) . Register's Signatur State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2010 Physician/ A M 2:45 May 24 Phoy Souvannavong Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Montgomery Hospice Casey House If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, June 25, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Birthpic Country Laos Social Security Number **Funeral** Months 1 X M 2 □ F Director 213-04-8949 85 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State the Maryland Director 1 Yes 2X No Suitland Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 20746 Laos 4802 Newland Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items within 72 hours after death 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Landscaping Groundskeeper Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) e 1 and 2 should be file of Health and Mental F fitem 27 is marked of Kaoe Siboivern Phat Siboivern 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19834 Bazzellton Place, Montgomery Village, MD 20886 Khemphet Chambers/Daughter other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Montgomery Crematorium. May 28, 2010 Bethesda, Maryland 4 Donation 5 Other (Specify) Rockville, Inc. 21. Signature of Funeral Service Ligenspe M01530 300 West Montgomery Avenue, Rockville, Maryland 20850 tonon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Advanced Liver Cancer Medical Due to (or as a consequence of) Examiner Hepatorenal Syndrome Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or liniury sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician thed for use as the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death sate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available 24a. Was an Was an autopsy performed?
Yes 2 1 No prior to completion of cause of death?

1 Yes 2 No certificate 26. Place of Death (Check only one) or Attending Physician: director, 25. Was case referred to medical Be Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice ဂ္ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director, After this 28a. Date of injury (Month, Day, Year) 28b. Time of funeral 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate; 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npleted Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the within 2 To the comple 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Joseph,

JUN 0

Bindu C. 31. Date filed (Month, Day, Year) D0060634

1160 Varnum Street, NE #21, Washington, D.C. 20017

May 24, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar			d / Depa	artme	nt of He	ealth a		ntal Hyg	iene	201	0 68	
			Decedent's Name (First, Middle, Last)							2			Vans	3. Time of Death	1
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tark.	Examir		4a. Facility Name (If not institution, give s	treet and number)	-		4b. City	, Town, or	Location o	of Death		4c. 0	County of Deat	h	
			6001 Windsor Mill	Rd.			Ba1	timor	`e						
	Funeral	Г	5. Social Security Number 6. Sex	M 257						Min.	(Month, Day,	Year)	9. Birt	hplace (State or Fore	sign
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	≥ 0220				10c City	Town or Lo	cation							10d. Inside City Lim	iits
, in a	sho in	ō	,	4b. City, Town, or Location of Death Baltimore Discrete Dis											
9	28a-f	ect	Doris E. Sparklin 4a. Fadily Name (if not institution, give street and number) 6001 Windsor Mill Rd. 5. Social Security Number 15. Social Security Number 16. Zip Code 16. Zip Code 16. Zip Code 16. Zip Code 16. Zip Code 16. Zip Code 16. Social Security New or No- 16. National Security Number 16. Social Security New or No- 16. National Security Number 16. Social Security Number												
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L To the Hospitel	within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Phys	ician: To the best o	f my know	viedae. deati	h occurre	d at the time	e. date an	d place an	d due to the co	ause(e)	and manner as	stated.	
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	0		30. Name and address of person who con	mpleted cause of de	ath (Item	23a) (Type.	Print)			- "		,		,, 7 0	_
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	Sta Registi		31. Date filed (Month, Day, Year)	32. Registr	f's Signat	ure A.	100	Me							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 24 Hrs Age (In yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) WV 235-44-9509 (Month, Day, Year, 01/29/193 1**X** M 2 □ F Months Hours Min Director Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Jessup 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò marked other than "natural", or items 23a o matic event, the Medical Examiner must be Funeral **USA** 7810 Clark Road TRLR C39 20794 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛛 No Black, White, etc. þ 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes. Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Construction Civil Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bradie Dickens C. E. Spratt off. Page 1 and 2 shours of Health and Mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7810 Clark Road TRLR C39, Jessup, MD 20794 Edna M. Spratt / Wife permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 Burial 2 X Cremation 3 Removal from State W. Arundel Crematory 05/28/2010 Odenton, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bailey Funeral Home and Cremation Service, 4023 Annapolis Road, Halethorpe, MD 21227 M0145 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of sician and burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? ō Month Day Pregnant at time of death 1 Yes 2 No the 9 Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page To the Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date fled (Month, Day, Year) aistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May th 26, 2:49 P M 2010 Philippe Francois Simard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5223 Springlake Way <u>Baltimore</u> Year If Under 24 Hrs.
Days Hours Min. Birthplace (State or Foreign Country) Texas . Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 🗆 F Days 19 9/18/1990 645-18-7054 **Director** Usual Residence of Decedent or 28a-f show be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director N/A Baltimore Marvland 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a o Funeral U.S.A. 5223 Springlake Way 21212 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ò 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natu ury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Education Student Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Monique Bellefleur IJ. Marc Simard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5223 Springlake Way Baltimore, Maryland 21212 19a. Informant's Name/Relationship (Type, Print) J. Marc Simard / Father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department o Important: If any injury or 1 Durial 2 X Cremation 3 DRemoval from State Hilltop Service. Corp 5/28/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Service cen Signature 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Nesen disease or condition resulting in death) Medical Due to (or as a contequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one, Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N wolk St DavidM 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month May 2010 08:03 ам David Elliott Swain Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson 13 Edgeclift Rd. 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Min. (Month, Day, Year) an. 14, 1954 New Jersey 1 🔀 M 2 🗆 F Months Hours 56 213-66-7198 Director Jan Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Examiner must be notified at rector Md. Baltimore Towson 1 Yes 2 X No Ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21286 13 Edgeclift Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Hygiene. other than "natural", or þ 1 Never Married 2 Married 1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) Salesman Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Juanita Covas Don Raymond Swain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Edgeclift Rd. Towson, Md. 21286 Mrs. Juanita Swain/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Removal from State 4 Donation 5 Other (Specify) 6-1-10 Hilltop Service Co. Towson, Md. 22. Name and Address of RUCK 1050 21. Signature of Funer Service Licensee Towson Funeral Home, York Rd. Towson, Md 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate on each line. Interval Between Immediate Cause (Final Onset and Death ⊲Pnysician/ ten1080 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence or, attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Dav Year 4 Pregnant 9 Unknown Pregnant at time of death Yes 2 No 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? 1 Tes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🗙 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to ompleted filled in by the funeral 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No M Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one of death (Item 23a) (Type, Print) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 19a, per FH G904 6/1/2010 TT State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Month Physician/ Frank Michael Skarupa May 10:00 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Country 1 St M 2 - F **Director** 213-34-1383 73 Yrs June 26 1936 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Harford Bel Air 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a of the Medical Examiner must be Funeral 21014 555 S. Atwood Road United States Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Felix Skarupa Frances Andrychowski permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is marl 19a, Informant's Name/Relationship (Type, Print) **Maria** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Lease / Daughter 619 Yankee Doodle Drive Bel Air, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Highview Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) Fallston, Maryland 2010 21. Signal Evans Funeral Chapel & 3 Newport Drive Forest any Cremation Services-BelAir Hill, Maryland 21050 23a. Part 1. Enter the disease, or constant shock, or heart failure. List only of ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LIVER CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) ng physician and as the burial-transit Exami Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Month Pregnant at time of death Yes 2 No 1 L Yes 2 L 9 Dunknown g Unknown as been signed by 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perforr death? 1 Yes Yes in 24 hours after death.

he Funeral Director: After this certific
pleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 X Natural injury work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 of person who compl ted cause of death (Item 23a) (Type, Print) JENNIFER HAUF CRNP 00 DULANEY VALLEY RD. TIMONIUM, MD 21093 State Registrar

10:00

2010

27

SKARUPA

FRANK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ М 0035A <u>William A. Taylor</u> Medical Mav 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Towson Balto. Gilchrist Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours Min. (Month, Day, Year, Country)
Maryland **Director 953** February 212-62-5500 Usual Residence of Decedent Il Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Md. Balto. Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2305 Covered Bridge Garth USA 21234 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give X
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Md. Environmental Service Enviromentalist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Edward J. Taylor Evelyn Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse Heidi Taylor 2305 Covered Bridge Garth Parkville, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Bayview 6-2-2010 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home un Ce 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hymorrhagic disease or condition resulting in death) days Medical Due to (or as a consequence Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transi Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the a d be detached f 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an page 2 performed? Yes 2 No certificate funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) 1 🗌 Yes 2 X No ᅆ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) CRNP May 28, 2010 R149194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 Charles MD 21204 Grah N. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 7/2009 JUN 0 1

Box 68760

P.O.

Division of Vital

10-04027 Corey Thomas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day May 26, 2010 Medical Examiner 1653 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9105 Live Oak Lane Upper Mariboro Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Months Days Director Min 38 9in 1a 1 M 230-06-762 2 F Country) Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No If item 27 is marked other than "natural", or items 23a or 28a-f sho her traumatic event, the Medical Examiner must be notified at once. Ittmore, MD 21215-0036

iit. Pages I and 2 should be filed within 72 hours after death with the Maryland urment of Health and Mental Higiene. Director 10e. Street and Number 10g. Citizen of What Country? 06 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 White, etc. Yes Yes, Give Year 4 Divorced 1 Yes 2 No specify: lack ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) a 17 Father's Name (First Middle Last) 18.Mother's Name (First, Middle, Be omas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - G 1 W Burial 2 Cremation 3 crematory or other place) Removal from State Denation 5 Other Specify ign, ture of Funeral Service Livens al Serv. ar STI Kalto. 23a. Part I. Enter the disease, or complications that caused the death. Do not e the mode of dying, such as cardiac or respir tory arrest, shock, or hear Physician failure. List only one cause on each line /Medical Between Onset and a. Hypertensive Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of). Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pua Physician/Medical e attending physician for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed his certificate has been a director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? Yes 2 V No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Director: 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifis 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 28, 2010 <u>ee</u> 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Victor Weedn MD JD Assistant Medical Examiner 32. Registrar's Squature State Registrar

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Exami		4a. Facility Name (if not institution, give	S MOSPIT		BALT	r Location of Death		4c. Count	y of Deatl	
Funeral Director		5. Social Security Number 6. S	M 2 □ F	(In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min. 1 47	8. Date of Birth (Month, Day, May 27,	^Y 2010	9. Birt Cou Mar	hplace (State or Foreigi Intry) yland
28a-f show	Director	10a. State 10b. County Maryland Baltimore		10c. City, Town or Perry Ha						10d. Inside City Limits 1 ☐ Yes 2 🕅 No
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ital Hygiene. 9d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Event Armed Forces? 1 ☐ Yes 2 XXN If Yes, Give Year or Dates.	er in U.S. 13	3. Was Decedent of H If Yes, specify Cuba 1 Yes 2 X No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ick, White	
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and Mer s marke umatic	P	Patrick Coetz 19a. Informant's Name/Relationship (1	., .	19b. Ma	illing Address (Street a	and Number or Rura	er Casalen	City or Town,	State, Zip	Code)
Department of Health and Mer Important: If item 27 is mark any injury or other traumatic once.		Patrick Coetz (Fath		4. 20b. Place of Dis	322 Cross Bro	ook Drive	Perry Hall	Maryla 20c. Location	and 21	128
outment of outant: If injury or injury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Service Licenses)	(y)	Evans Fun	ematory or other place Tral Chape	≥1 MAY	29,2010	Fore	st H	Ii11,MD
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Medical xaminer	Examiner	shock, or heart failure. Listlonly of Immediate Cause (Prinal disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	a. Cardia	onsequence of):	ecq	\				Interval Between Onset and Death
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been signed by the should be detached	ا ۾	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did toba			the cause of death?
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r this certificate ral director, pag	8	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Othe	ace of Death (Check				
h. Afte fune	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Y	2 ER/Outpati 28b. Time injury	of 28c. Injury	4 Nursing Ho	me 5 Residen			y)
within 24 hours after death. To the Funeral Director: A completed filled in by the fu	al Certificate;	3 Suicide 6 Could not be 4 Homicide determined		- At home, farm, s Specify)			28f. Location (Stre City or Town,		er or Rura	I Route Number,
nin 24 hou the Funer npleted fill	Medical	only one) 3 Certifying Nurs	sician: To the best of my ner: On the basis of exan e Practioner: To the bes	nination and/or inve	stigation, in my opinio	n, death occurred at	the time date and	place, and du	e to the co	use(e) and manner state
To CO		29b. Signature and title of certifier	R		29c, License Res	number	290	d. Date signe		Day, Year)
		30. Name and address of person who c	ompleted cause of deat N・WoLF以	h (Item 23a) (Type,	Print)	BALTIMO	NE MN	21)	97	
	е	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		. 1.4- 11,410	1		- 4	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death L. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 24^{Day} Nellie Anne Wingate Manth Marth 2010 8:25a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sun Valley Assisted Living Westminster Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □XF Months Days Hours Sept 29 Country) 97 220-14-1405 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Westminster 10d. Inside City Limits Director Carrol1 MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21157 805 Wilda Drive 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify. Specify:white 3 K Widowed 4 □ Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2. College (1-4 or 5+) banking Elementary/Seconday (0-12) bank teller Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ John M. Gavin Anna M. Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Burke (son) 6019 Snowdens Run Rd., Sykesville, MD 21784 Health tem 27 Department of Health Important: If item 27 any injury or other to Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Lake View Memorial 5-27-10 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral flome & Chapel 21. Signature of Funeral Service Licenses P.O. Box 195 Sykesville, MD 21784 MO0764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Carcinoma mon Sequentially list conditions, if any, leading to numerical cause. Enter Underlying Cause (Disease or iinjury Exami been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 L 9 Unknown a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? certificate has page 2 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: After this certific
mpleted filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? assis Hospital Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the 29b. Signature and 29d. Date signed (Month, Day, Year) 2 16206 2010 ELDERSBURG, MD 21784 who completed cause of death (Item 23a) (Type, Print) 13 80 ROGRESS Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (Hirst, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 55 4M 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution. give street and number Examiner VIRU Unde Year If Under 24 Hrs 8. Date of Birth (Month, Day, Security Number 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 M 2 K 216-30-7979 Usual Residence of Decedent 6 Yrs. 933 are Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code Street and Number 21222 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Completed by Specify: 13 lack 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any injury or other traumatic event, the Mesonce. Elementary/Secondary (0-12) College (1-4or 5+) leacher 12 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Name and Addres 21. Signature of Funeral Service Licensee 212/7 baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e Immediate Cause (Final disease or condition resulting in death) Atheros clendra **Physician** /Medical Examiner ardiomyo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknow P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of o 28/10 0-41399 bo completed cause of death (Item 23a) (Type, Print) / 6 🗸 🕏 North 30. Name and State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2010 Year Hattie Ε. May 25 12:31 A.™ Welch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11232 Old Hopkins Road Clarksville Howard Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X X Days Hours 218-24-2328 02-14-1925 Director 85 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11232 Old Hopkins Road 21029 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ğ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: Completed 3 KWidowed 4 Divorced White Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natuury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lyman Lewis Souder Catherine M. Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 Oakville Drive, Crownsville, Maryland 21032 Robert W. Ryan - grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important; If ite any injury or ot 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem. Gnd. 05-29-2010 Marriottsville, MD 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature o Fune al Service Lid MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line End STAGE COPD Immediate Cause (Final Onset and Death Physician Medical resulting in death) Due to (or as a consequence of): 24hrs **Examiner** Sequentially list conditions, if any, leading to immediate Examine Hospital or Attending Physician: The law requires that the death certificate be executed tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 🔀 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident within 24 hours after death. To the Funeral Director; A 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number completed filled in by determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death baccurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) May , 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LEALAZAR MD 6355 TEM LARKSVILLE TENOALS RY STE 202 2102

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Regis ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onnial Williams	•	State o	f Maryland / Depa Cei	artment of rtificate of		d Mental H	-	201	0 1682
Physicia Vledical Exami	n/	1. Decedent's Name (First, Middle,Last)	Villiams	Jr			2. Date of Deat Month May 26, 20	h Day Year	3. Time of Death 1848 hrs
		4a. Facility Name (if not institution, give s 3800 Milford Mill Road @ Do		,	b. City, Town, or Milford Mill	Location of Deat	n	4c. County of Deat Baltimore Co	
Funeral Director		5. Social Security Number 6. Sex 1 X N	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		_	h(MM/DD/YYYY) 9. Bi Forg	rthplace (State or gny
d how any		Usual Residence of Decedent 10a. State 10b. County A	Λ.	Town or Locati		V: 1/			10d. Inside City Limits 1 X Yes 2 No
r death with the Maryland or items 23a or 28a-f she inust be notified at once	Director	10e. Street and Number	nore M	(11)as	10f. Zip Code	244	10	Og. Citizen of What Cou	intry?
hours after death with the Maryland 'natural', or items 23a or 28a-f sh Examiner must be notified at once	Funeral	1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No Yes, Give Year		s Decedent of His es, specify Cuban	, Mexican, Puerto		White, etc.	rican Indian, Black,
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MD 2121 d 2 should be the and Mental in 27 is marked unmatic event	To Be	19a. Informant's Name/Relationship (Typ	Villiams, oud (france)	19b. Mailing	Address (Stree	t and Number or	ural Route Num	JONNSON ber, City or Town, State WindSorV	
Baltimore, I bermit. Pages 1 and Department of Heal Important: If item		20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other Specify:	20b. l	crematory or oth	Darl		Date 3-10	Baltmo	
		27) Signature of Funeral Service License 28. Part I. Fatter the disease, or complice	were		ame and Address	MUIMOI	e va	eral Servi	ces ZIZZ9 Approximate Interval
Physician Illudical Examiner		failure. List only one cause on each Immediate Cause (Final disease a. M			one do en dy inig,				Between Onset and Death
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Box 6876 e death certificate the attending phy ed for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Live birth Pregnant at time of de Unknown		al death 3 [ner (Specify)	Ectopic pregn	ancy	Month	Day Year
ires that the direction signed by the	<u>آھ</u>	Part II. Other significant conditions co	ontributing to death but not re	esulting in the u	nderlying cause g	iven in Part I.		bacco use contribute to	
Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Completed						24a. Was a autope perfor	sy prior to death?	utopsy findings available completion of cause of es 2 No
Vital Rec ysician: The his certificate director, page	å	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	pital: 1 Inpatient 2	ER/Outpatient	, marca	of Death (Check		Residence 6 🗸 Othe	r; Scene
ision of \Attending Phy or death. rector: After the	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) May 26, 2010	28b. Time of Ir 1840 hrs	`	ry at Work? /es 2 🗸 No	28d. Describe h	ow injury occurred or cycle struck ca	
Divis spital or At nours after d neral Direct filled in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho (Specify) Local Stree		t, factory, office b	uilding, etc.	or Town, St	tate)	ural Route Number, City Avenue, Milford Mill,
To the Hospita within 24 hours To the Funeral completely fille	Medical	one) 2 Medical Examiner: 0	 To the best of my knowledgest the basis of examination and manner stated 						
F 2 F 8	Me	29b. Signature and title of certifier	MA.	1	29c. Licenson			29d. Date signed (Mo	onth, Day, Year)
121		30. Name and address of person who cor Zabiullah Ali, M.D. Assista	ant Medical Examiner	111 Pen	n Street, Balti	imore, MD 21	201		
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 5/26/2010 Ellen N. Wachter 11:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carrol] If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Hours Min. 3/13/1922 Director 577-20-0253 88 MD Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 110 Terrapin Dr. 21784 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Maryland 21215-0036 I Hygiene. other than "natural", 1 ☐ Yes 2X No Specify: Specify Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Baltimore Co. Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of Wilbur F. Nash, Jr. Alice Smith permit. Page 1 and 2 should the Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Wachter/Son 2583 Vance Dr., Mt. Airy, MD 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State injuny 4 ☐ Donation 5 ☐ Other (Specify) 5/29/2010 Patuxent Cemetery Sunshine, MD 21. Sign of Funeral Service License Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, ort 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death Pnysician/ Medical IALEd Ischmil CARDIUMY OPAHL dis- se condition resu in in death) LIEAR Due to (or as a consequence of) Examiner Coronau Luetas DISEASY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attendion abundance. the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Unknown be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 1 No 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number D31660 2312010

Registrar

291 STOWER AVENUE

24157

MARYLAND

WESTMINSTEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS

K- GALVIN III MO

10-03967 Aaron Waltmeyer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2010 | 5830

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Sequentially list conditions. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due	
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Physician Medical Examiner 23. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. 23. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. 24. Contact Gunshot Wound of Head 25. Equantially list conditions, if any, leading to immediate events resulting in death) Last 26. Equantially list conditions, if any, leading to immediate events resulting in death) Last 27. Contact Gunshot Wound of Head 28. Equantially list conditions, if any, leading to immediate events resulting in death) Last 28. Equantially list conditions, if any, leading to immediate events resulting in death) Last 29. Due to (or as a consequence of): 29. Due to (or as a conseque	ie
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The first of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Continuous Continuous Continuous	227)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 25, 2010	ar j
30. Name and address of person who completed causar of death (Item 23a)	
Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 32. Registar's Signature Registrar 111N 0 1 2010 Server 5.	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Margaret G. Wingate 2235 25 2010 MAL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMUNE AGNURS 8. Date of Birth (Month, Day, Year Aug 21, 1 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F Months Days Hours 215-34-9057 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Anne Arundel Pasadena 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2307 228th Street 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Banks Hart Lena Irene Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Valerie Justice/Daughter 285 Cape Sable Court Pasadena, Maryland 21122 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) May 30, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Glen Burnie, Maryland 2010 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licena 22. Name and Address of Facility Singleton Funeral & Cremation MO1580 1 2nd Ave. SW Glen Burnie, MD 21061 Services PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Peninheral Due to (or as a consequence of): VASCULAR disease or condition resulting in death) Anteny DISPAST thero slerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Lipedemin Due to (or is a consequence of): that initiated events resulting in death) Last ension EN 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STOGE RENAL 1 des 2 No 3 Probably 4 Unknown Femoral EndoonHerectomy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 1 ☐ Yes 2 ☐ No 2 🗆 26. Place of Death (Check only one)

Physician /Medical Examiner burial-transit

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attending physician for use as the burial

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After this certificate has funeral director, page 2 s

within 24 hours after death

To the Funeral Director: All
completely fille in by the fu

or Attending Physician:

Physician

/Medical

Examiner

MD

Directo

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at

Saltimore, Maryland 21215-0036

MARGINE

Box 68760,

Ö

Vital Records,

Division of

Examine Physician/Medical ş Completed

Be

Certification: To

ical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

and manner stated.

25.	Was case examiner?		 medica
	1 ☐ Yes	2 No	 _

27. Manner of Death 1 Natural

6 ☐ Could not be

determined

Hospital: 28a. Date of Injury (Month, Day, Year) 5 Pending investigation

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 🗆 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

4 ☐ Homicide

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

D0040085

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person of death (Item 23a) (Type, Print) CATON AVENUE BALTIMOND, MD 900 - nues

In thony 31. Date filed (Month, Day, Year)

32, Registrar's Signatur

Registrar

8

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Adolf Werner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death of maryland medical athmore 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 M 2 □ F **Funeral** Country) Months Hours Dec Nonth, Pay, Year 38 Director 577-56-7622 71 Germany Usual Residence of Decedent 28a-f show 10c. City. Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Frederick Mt. Airv 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 21771 14901 Harrisville Road USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Maria Hager Gottfried Werner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Roubik / daughter 3737 10th Ave SW: Rochester. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🕅 Cremation 3 🗆 Removal from State cemetery, crematory or other place injury or 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 5/28/2010 Towson, MD 22, Name and Address of Facility any in 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Oaset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a corts transit Hospital or Attending Physician: The law requires that the death certificate be executed motor and that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death signed by the aid be detached for 2 No Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Coronary arter certificate has page me I ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 ¥ Yes 2 ☐ No ဂ္ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 233 work? 1 ☐ Yes 2 💢 No 1
Natural 5 Pending 2 X Accident 3 ☐ Suicide Investigation motor vehicle callision 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State
Route 27 Street mount thiry 24 hours a Funeral L 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c, License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

STEERO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State	State of M	arylan		artmer <i>rtificat</i>			and M		_	0.7	310	1	- 0 0
	Physicia	n/	1. Decedent's Name (First, Middle, Las Xi Chi Xie	st)	_	007	incat	<u> </u>	Catri		2. Date of Dea Month May 25		-	Year	3. Time of 12:46	
	Medic Examin		4a. Facility Name (if not institution, give	street and number)			4b. City	, Town, or	Location of	of Death	may 23		c. County o	of Death		
			Shady Grove Adve				Rockville					M	lontgo	mery		
	Funeral Director		231-01-2430	Sex 7.Ag XIM 2 □ F	79 (In yrs. la	ast birthday) Yrs.	If Unde Months	Pr 1 Year Days	If Under Hours		8. Date of Birl (Month, Da February	$3^{\text{(ear)}}$	1931	g. Birthp Count Chi	lace (State o ry) na	r Foreign
	nd how at		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							1	0d. Inside Ci	ty Limits
	faryla Ba-f s tified	Director	Maryland Montgomery 10e, Street and Number				Rockville							1 X Yes	2 🗆 No	
	the N a or 23	١٥					10f. Zip Code				10g. Citizen of What Country?			try?		
	h with	Funeral	13614 Mills H						0850			Ch	ina			
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural" or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give			1	If Yes, spe	cify Cuba	spanic Orig n, Mexican Specify:	ı, Puerto R	ify Yes or No- ican, etc.)		14. Race Black Specify:	, White, e	etc.	
Baltimore, Maryland 21215-0036	hours natura lical E	lete	15. Decedent's E			16a. Dece						16b.	Kind of Bus			
2	nin 72 ne. han " e Mec	шо	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)				kind of wo O NOT us	ork done d e retired)	luring most	t of workin	g					
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and	be file antal H ked o c eve	10 E	Chi Chow Xie	د							(First, Middle, oi Wong		n Surname)			
ary	nd Me		19a. Informant's Name/Relationship (7			19b. Mailii	na Addres	s (Street a					or Town, St	ate. Zip C	(ode)	
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ore	of He If item or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3	3 Removal from State		emetery, crer	natory or	other plac	e)	June	^{at} f,	20c.	Location - (City or To	wn, State	
ij	t. Page 1 tment of tant; If it tjury or o		4 ☐ Donation 5 ☐ Other (Speci	ify)	Gat	e of I	leave ry	n		2010		Si	lver :	Spri	ng, Ma	rylan
Bal	permit. Page 1 Department of Important; If i any injury or o		21. Signature of Funeral Service Licen	1 1	1498	22	Name a OCKV	ille ille	s of Facilit Inc Mar	y1anc	ert A. West 20850	Mon	phrey	ry A	venue	iome/
A.)	Physician/	G 7	23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each lin	e.						respiratory ar Diseas				Approximat Interval Bet Onset and I years	ween Death
	Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):										
	ed sit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	uence of):												
0	ate be executed oblysician and the burial-transit	dical Examiner	that initiated events resulting in death) Last													
3760	ficate g physas the	Nedi		• d												
Box 687	e death certificate be executed the attending physician and thed for use as the bunal-transif	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)					23d. Date Mon		,	Year			
s, P.O.	requires that the de been signed by the should be detached	d by Ph	Part II. Other significant conditions of	ontributing to death t	but not res	sulting in the o	underlying	cause giv	ven in Part	l.	1 _	d tobacco use contribute to the cause of death? ✓ Yes 2 □ No 3 □ Probably 4 □ Unknow				
ord	/ requ	lete	Hypertension			·					24a. Was	an	24b. W	/ere auto	osy findings	available
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ital	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	ace of Dea							
<u>></u>	r this	일:	1 ☐ Yes 2 🛣No 27. Manner of Death	28a. Date of inju	ury	ER/Outpatie 28b. Time o		OA DOA	4 🗆 IVI		ne 5 🗌 Resi 8d. Describe t)	
UC C	nding ath. r: Afte ie fune	icat	1 X Natural 5 ☐ Pending 2 ☐ AccidentInvestigatio	on (Month, Da	ay, Year)	injury	м	work	? Yes 2 🗆	- 1		se now injury occurred				
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	al Certificate:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined				reet, factory, office 28f. Location				on (Street and Number or Rural Route Number, Town, State)					
	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	ysician: To the best of niner: On the basis of e rse Practioner: To the	examinatio	n and/or inves	stigation, ir	my opinio	on, death or	ccurred at t	the time, date a	and pla	ce, and due	to the car	use(s) and ma	nner stated
_	Vit Vit		29b. Signature and title of certifier	da lla			29	lc. License					ate signed			
			To the state of th	311 - /		- 00+) (T	Duint)	D53	317			Ma	y 25,	2010)	
			30. Name and address of person who Joseph A. Ball,		,	, , , , .		. #2	13. ദ	aitha	ersburg	. N	[arv1s	and 2	.0877	
į	Sta		31. Date filed (Month, Day, Year)	32. Pagistr	rar's Signa		back		., .			, ,				
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 26, 2010 10:53A Robert Henry Young Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Hours September 27,1942 New York 67 Director 213-42-7937 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Tant if item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 X Yes 2 No 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 502 Pinewood Road 20850 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Land Surveyor Surveying Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Kenneth Young Sara Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance V. Young/Wife 502 Pinewood Road, Rockville, Maryland 20850 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot May Date 9. cemetery, crematory or other place 1 Burial 2 K Cremation 3 Removal from State Montgomery, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland 22. Name and Address of Facility Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 . Signature of Funeral Service License M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death 50 minutes Immediate Cause (Final Physician/ Acute Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiopulmonary Disease 15 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician at the detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autopsy performed death? 1 Yes 2 No Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No ပ 1 Inpatient 2 X ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director,

completed filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, doubt one at the time, date and place, and due to the causely) and manner as stati 29b. Signature and title of certifier MO 68219

Registrar DHMH 17 Rev 7/2009

State

Morcos, no 990/ Medical Center Deire Rochulle MA

M.D

ress of person

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Patrick John Young May 2010 10:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick 8606 Hunters Drive Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗆 F Months Hours March 17 213-66-4843 56 Director 1954 Washington, D.C. Usual Residence of Decedent or 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 Tes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8606 Hunters Drive 21701 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 X Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other the Firefighter County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Benjamin Young, Sr. Katherine Cuzic L. other traumatic permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jimmy W. Trout /Nephew 8606 Hunters Drive, Frederick, Maryland 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 🔀 Cremation 3 🔲 Removal from State May injury or Montgomery Crematorium, Inc. Bethesda, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. any M01305 Jangell 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ NEUMONI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner YORK Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause injury Due to (or as a consequence of): the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 2 40 Completed 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 certificate 1 🗌 Yes 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No 1 Yes 2 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 28d. Describe how injury occurred Natural 5 Pending iniury s after death, I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signatu 29c. License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar trar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health Amend Hygiene 25,27,28a i per me, g 04,06/69/2016 Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Myron Allen 2:20 pM 2010 Mau Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 17.1 Funeral 6. Sex 1 M 2 D 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours New Jersey 143-24-4515 Director 77 June Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Silver Spring 1 Yes 2 X No Montgomery 10e. Street and Number 5 10f. Zip Code 10g Citizen of What Country? "natural", or items 23a 15100 Interlachen Drive, 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No 1957
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced White 1963 Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Physicist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Allen Bessie Buchinsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hannette Allen - Wife 15100 Interlachen Dr.. #914. Silver Spring. MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of competery, crematory or other place)
Baltymore Crematory
at Loydon Park 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗀 Removal from State 05/22/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave.. Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Immediate Cause (Final Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Coronary Atherosclerosis 10 years Securitially list or ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Subdural Hematomas cate has been sig page 2 should b Completed 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Chronic Metastatic Lung Cancer 24a. Was an autopsy performed? Yes 2 X No certificate this certifica 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 X No Other: 은 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera 28d. Describe how injury occurre Multiple falls Natural Accident 5 Pending Unknown_M work? 1 ☐ Yes 2 🔏No Unknown Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Unknown** 28f. Location (Street and Number or Rural Route Number, City or Town, State Unknown Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ₃ 🗖 29d. Date signed (Month, Day, Year) D0035045 May 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip G. MD 18109 Prince Philip Drive, #200, Olney, Maryland 20832 Henjum,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) MAY 25 2010

Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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П	Physicia	an	1. Decedent's Name	(First, Middle, La	st)					2. Dete of De Month	eeth Dey	Year	3. Time of Death
	/Medic					Rydstro	m Blai				5/10/20		6:15 AM
j.	Examin	er	4a Fecility Neme (If			·				r Location of Dee	th 4c. Cour	ity of Death	
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	Funeral Director		5. Social Security Nu 214-14-12 Usuel Residence of	11	M 2⊠F	. Age (In yrs. la	.,	Months Days	Hours Mi		71920		plece (State or Foreign otry) Land
	yeur #			10b. County		10c. City	, Town or Loc	cation					0d. Inside City Limits
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	1h wil	aiD	710 Am	ericana	Drive, #	16		2140	3		US	SA	
	eep L	Ine.	11. Marital Status		12. Was Deced Armed Ford		6. 13. V	Vas Decedent of H Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	o- 14. R	ace - Americ	
21215-0020	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Merylend Depertment of Heelth end Mentel Hygiene. Important: If them 27 is marked other than "natural", or theme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Marrie	_	1 ☐ Yes 2 If Yes, Give Year or Dat	No No		□Yes 2√∏No	Specify:			ecity: White	
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Division of Vital	or Att	Ē	4 ☐ Homicide	determined	28e. Place of	f Injury - At hor , etc. <i>(Specify)</i>	ne, farm, stre	et, factory, office			(Street and Nur own, State)	mber or Rur	el Route Number,
_	pital ours oral [ပ္	29a. Certifier 1	ertifying Ph	veiclen: To the he	et of my know	ledge death	occurred at the tir	ne date and nise	e and due to the	cause(s) and	mannar as s	tated
	To the Hospital or Attending Physician: The is within 24 hours efter deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medicai Certification:	(Check only 2 one)	Medical Exam	niner: On the basi	is of examination	on end/or inve	estigation, in my o	pinion, death occ	curred et the time	, date and place	e, and due t	o the cause(s)
	To the comp	M	29b. Signature and ti	e of certifier	110	Λ -		29c. Licens			29d. Date sign	ned (Month,	Day, Year)
	. / (A		> 1N	Jak 11	NUU	4		0	51819		ME	10.2	010
	PCKL		30. Name and eddres		completed cause	of death (Item :	23e) (Type, P	vint)			0	-	
	10		Mati		multa	13:	2 Hill	log CT	s-ite:	241 An	-4polis	MD	51201
	Stat Registra	е	31. Date filed (Month	, Day, Year) MAY 122	2010 32. Reg	istrer's Signetu	A. A	backs					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Ethel A. Brooks 1:56 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Cent Glen Burnie HAME Arunde If Under 1 Year **Funeral** Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Mental) 1 and 1 □ M 2 □**X**F Days Min. F (Month, Day Year) 939 216-36-2148 71 **Director** Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified lary1and Anne Arundel Severn 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8599 Pioneer Dr. 21144 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1XXNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ΪXNo Specify: If Yes, Give Year or Dates. Black Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Custodian Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental မ George W. Brooks Gertrude C. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 8599 Pioneer Dr. Wanda P. Spriggs(Daughter) Severn, Md. 21144 20a. Method of Disposition 20b Nilece of Disposition (Mame of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5-12-10 U.M. Church Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Marne Masse of ShiitSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 1, 1000 MC0 483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ YAN GUINATION disease or condition Medical resulting in death) Examiner 20 Minuit 11 Emounater Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) 1 WUFIC burial-transif resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 10 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 🔲 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) I Director; After the in by the funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Tyes 2 🗌 No Accident Investigation 6 Could not be 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) thin 24 hours a the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check within 2 3 🗆 Certifying Nurse Practionen To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

13:04

31. Date filed (Month, Day, Year

HOSP:MZ

32. Refistrar's Signature

BULLVIE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			For State Registrar	tate of Ma	arylan	•	artment of F tificate of E		Mental Hygi	ene Z		0 46839
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imore	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1	oval from State	C	emetery, crem 2an Mei		rdns 05/1	14/2010		Mar	yland
Ball	permit Depart Impor any inj		21. Signature of Funeral Service Licensee	0#1070	t							Home, Inc. 1g, MD 20904
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	30		29b. Signature and title of certifier	mo			29c. License	939793	29	9d. Date signed May	13,	
			30. Name and address of person who comp Christopher J. May	s, MD,	1811	1 Prin	ce Philip	Drive,	#207, Ol	ney, Ma	vryla	nd 20832
	Sta Registra	te ar	31. Date filed (Month, Day, Year) MAY 14 2010	32. Registra	r's Signat	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05/10/2010 JACOUELINE BAH M 0029 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X Hours (Month, Day, Year) 07/28/195 Director 579-72-3641 57 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Tes 2 X No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12325 New Hampshire Avenue 20904 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. . or 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Widowed 4 Divorced Year or Dates Black marked other than "natu matic event, the Me fical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Cook Manager Canteen Cafeteria Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jimmie Parrott Wilhemina Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 permit. Page 1 and 2 2.... Department of Health an Important: If item 27 is Alpha M. Bah - son 18531 Boysenberry Drive, #290, Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Souls Cemetery 4 Donation 5 Other (Specify) 5/18/10 Germantown, MD Funeral Service Licer 21. Signatur of 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one ca ions that caused the death. Do ause on each line. Aenter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or lingury that initiated events Pneumonia physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? detached for Month Day Year the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End stage renal disease 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy After this certificate Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital 2 🔀 No Other: 1 Yes |은 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No fter death. Director Aft 2 Accident
3 Suicide Investigation pleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State 24 hours Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one) 29b, Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

Kshama Garg 1 31. Date filed (Month, Day, Year)

1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

32. Registrar's Signature

D60826

5/10/10

For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 15, 2010 May 10:34 A M RONNIE WAYNE BENTLEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 26674 Johnson Creek Road Crisfield Somerset 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex Months Days Hours Min 1 M 2 □ F Yrs Director 70 14, 1940 Virginia 212-36-3726 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Province Exercitive must be rediffied at 1 ☐ Yes 2X No Director Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21817 USA 26674 Johnson Creek Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Navy If ¥ês, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: <u>≥</u> Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Della Bishop မ Robert E. Bentley, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26674 Johnson Creek Road - Crisfield, MD 21817 Barbara L. Bentley (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If Its any injury or o oonce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 17, 2010 | Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) of Delmarva Funeral Service Lig 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME <u> 306 W. Main Street - Crisfield, MD 21817</u> 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** anno disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by icate has been si ; page 2 should t 1 ☐ Yes 2 1 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 □Yes 1 ☐Yes 2 ☑No 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 ☐ Other (Specity) funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D-39813 May 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atkins, M.D. - 201 Hall Highway - Crisfield, MD 21817 31. Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Maryland		nt of Health and te of Death	Mental Hygie	2016	16842
Physicia		1. Decedent's Name (First, Middle, Last) Norma Lee Bunt	ing			2. Date of Death Month 05-06-	Day Year -2010	3. Time of Death 9:55 A M
/Medic Examin		4a. Facility Name (If not institution, give str 14643 Bauer Dr	eet and number)		r, Town, or Location of Dea		4c. County of Deat	h
Funeral Director		5. Social Security Number 6. Sex 1 □ 1	7. Age (In yrs. la		er 1 Year If Under 24 Hi		(ear) 9. Birt	hplace (State or Foreign buntry) DC
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom 10e. Street and Number 14643 Bauer Driv 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest grade of the county o	(Specify Yes or No- erlo Rican, etc.) Norking Palame (First, Middle, Malawson Rural Route Number, 6	Specify: Whi 16b. Kind of Business/Ir Private Ir ie (First, Middle, Maiden Surname)				
permit. Pages 1 and Department of Healt Important: if item 2 any Injury or other once.		20a. Method of Disposition 1 Burial 2 Notremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee May 1 Ragman	moval from State Riv	erdale C 22. Name	r em. 05- and Address of Facility	Date 2010 1 1 1 1 PA A	Riverdal	Town, State e, Marylar 20746 land, MD
Physician /Medical Examiner	ical Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Acute Myoc Due to (or as a consequence to (or as a co	cardial l mence of): Atherosci	Infarction	liac or respiratory arres	st,	Approximate Interval Between Onset and Death Immediate
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	ic. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown		23d. Date of d Month	elivery Day Year		
uires that n signed b lid be deta	2	Part II. Other significant conditions conf	ributing to death but not resu	ulting in the underlying	g cause given in Part I.			to the cause of death? Probably 4 ☐ Unknowr
The law rec cate has bee page 2 shou	Completed	Atrial Fibrill Osteoporosis	ation			24a. Was an autopsy perform	prior to	autopsy findings available completion of cause of s 2 □ No
sician; certifii irector,	Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatient 3 □		Death <i>(Check only one</i>		nocify)
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide	28d. Describe ho	w injury occurred	Rural Route Number,			
Hospital 24 hours a Funeral C	Medical Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death occur ation and/or investiga	red at the time, date and p tion, in my opinion, death o	lace, and due to the ca occurred at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
To the within To the comple	Mec	29b. Signature and title of certifier			29c. License number		Pd. Date signed (Mo	
R		30. Name and address of person who con Philip Henjum,	mpleted cause of death (Item	n 23a) (Type, Print) Prince I	hilip Dr.	,Ste.200,	Olney, N	4D 20832
St	ate	31. Date filed (Month, Day, Year)	32. Registraris Signa	arke				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:52 Blair May Dollie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. May 14, 1927 Maryland Director 215-20-9934 83 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19336 Longmeadow Rd. 21742 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. and Mental Hygiene. is marked other than "natural", or þ 1 ☐ Never Married 2 🕅 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be Department of Health and Member I Begar and 2 should be file Department of Health and Member I Important If item 27 is marked of any injury or other traumatic accordance. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Allen Daniel Baker Mary Gossard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Blair/Husband 19336 Longmeadow Rd., Hagerstown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park 5/24/2010 4 Donation 5 Other (Specify) Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Smal disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying and -transit Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Box 68760 nding p IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ģ in the past 12 months? Month Day Year Pregnant at time of death
Unknown signed by the a Yes 2 4No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1115 Tay 2 N 2 No Yes 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner Peath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending ~ Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

State

Francisco

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniels

11006111

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 2010 16 0335 Dora Anna Curtin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert Memorial Hospital Calvert 8. Date of Birth (Month, Day, May 28, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours Min. 1□ M 2₩ F Marvland 579-12-2227 89 1920 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show ed other than "natural", or items 23a or 28a-f show event, the theolical Examinar must be notified at 1 ☐ Yes 2☐ No Directo Maryland Anne Arundel Churchton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20733 5734 Broadwater Creek Road United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 □ No If Yes, GiveX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 📉 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatin months. Elementary/Secondary (0-12) College (1-4or 5+) Secretary U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Otto Wieland Anna Marie Diskau 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Earl Curtin / Son P.O. Box 554 Churchton, Maryland 20733 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) First Lutheran 05/20/2010 | Laurel, Maryland 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 8325 Mt. Harmony Lane, Owings Maryland 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** /Medical Due to (or as a consequence of): Examiner AMOONISMS SAIMOONISM STREPTOCCOCD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed burial-tran and Due to (or as a consequence of): Box 68760. attending physician requires that the death certificate be Physician/Medical the as for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 HUPER NATREMIA 1 Yes 2 No 3 Probably 4 Vunknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DEHYDRATION 24a. Was an 1 ☐ Yes 2 ☐ No PAILURG Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 € No 1∐ Yes Certification: To this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Matural death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attence within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

dew 10

State Registrar PRINCE

1000649610

CM

FREDGRICK

MI

32. Registrar's Signature

ROAD

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ 9 11:17A^M May Rufus Ρ. Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day,) May 18, 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Hours Min. Kentucky Director 230-28-5356 1927 May Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2409 34th St., 20020 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2 K Married 1 X Yes 2 No 1950 If Yes, Give 1952 Year or Dates. 1952 Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Specialist Government Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Katie Perrv Charles McKinnev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2409 34th St., SE Washington, DC 20020 19a. Informant's Name/Relationship (Type, Print) <u> Anna Charles/wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 5/14/10 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cemetery Suitland, Md 21. Signature of Funeral Service Licensee 23 Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INF ARCTION Ph sician/ ACUTE MYOCARDIAL Medical Due to (or as a consequence of): Admi Hed Examiner ARTERY PASEASE CORONARY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) 18CHEMIC attending physician and for use as the burial-transi ARBIOMYOPATH the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) 5/9/10 at resulting in death) Last Physician/Medical CARCINIMA of the PROSTATE METASTATIC Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant a Pregnant at time of death 5 Other (specify) 2 🗌 No 1 Yes 2 Unknown the r signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEPENDANT BIABETES MALLITUS Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen MY PERTENSIVE MEART DISEASE 24b. Were autopsy findings available prior to completion of cause of 24a, Was an nas autopsy perform certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗹 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မ 1 🖾 Inpatient 2 □ ER/Outpatient 3 □ DOA within 24 hours after death.

To the Funeral Director. After this of completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

MA 10,87. PATRICKS BRIVE, SUITE 208, WALDER, MD 20603 IMMUL 31. Date filed (Month, Day, Year) MAY 1 7 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

only one

29b. Signature and title of certifie

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

135295

29d. Date signed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 5 2010 Chatham, Sr. 23:22 M Grover Todd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Wicomico Peninsula Regional Medical Center Salisbury If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-24-1945 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 0ays 1 🕅 M 2 🗆 F Director 215-44-6457 Maryland Usual Residence of Decedent ıral", or items 23a or 28a-f shov I Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must he matter at a 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 X No MD Somerset Princess Anne 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 13857 Reading Ferry Road 21853 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Completed by ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Correctional Maint. Officer IICorrectional Institute Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Grover Floyd Chatham Nina Mae Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3857 Reading Ferry Road, Princess Anne, MD 21853 <u>Judy Chatham - Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-15-2010 Barren Creek Cemetery Mardela Springs, MD Signature of Funeral Service Licen 22. Name and Address of Facility Bounds Funeral Home E. Main Street, Salisbury, Maryland 21804 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final Onset and Death Physician/ mou disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed? 2 🗌 No Yes 2 🗆 N 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗌 No Other: 1 🔽 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pocomokelin 2185 305 AUL 31. Date filed (Month, Day, Year, State

Registrar

10-03808 Robert Cuthbert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Cuthbert	1- For State	Department of l Certificate of l	Health and Mental H Death		201	0 1681			
Physician/	1. Decedent's Name (First, Middle,Last)			2. Date of Death	No. L U	3. Time of Death			
Medical Examine	Anthony Robert 4a. Facility Name (if not institution, give street and number)		o. City, Town, or Location of Deatl	May 18, 20		0937 hrs			
	Washington Adventist Hospital	1	Takoma Park	•	Montgomery				
Funeral	5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year If Under 24Hr		(MM/DD/YYYY) 9. Birti	nplace (State or Trunidad			
Director	220-98-6478 1XM 2 F	51 Yrs.	Months Days Hours Mir	June 1	1,1958 Col	intry) & Tobago			
ny .	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	n			10d. Inside City Limits			
nd show a	Maryland Montgomery	Takoma Pav							
the Maryland n or 28a-f show any tified at once. Director	10e. Street and Number		10f. Zip Code		g. Citizen of What Coun	try?			
th the ?	7704 Blair Road, #101		20912		rinidad &	Tobago			
er death with t	11. Marital Status 1 \(\foating \) Never Married 2 Married Armed Forces?	If Yes	Decedent of Hispanic Origin? (S s, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,			
frer de	3 Widowed 4 Divorced If Yes, Give Year	X No 1 Y	res 2 X No specify:		Specify:	Black			
nours aft	I or Dates: 15. Decedent's Education (Specify only highest grade com-	during mos	s Usual Occupation (Give kind of st of working life, DO NOT use ret		6b. Kind of Business/Ir				
5-0036 ed within 72 hour lygiene. other than "natu	Elementary/Secondary (0-12) College (1-4 or 5	5+)	struction Worke		Court	+++++++++++++++++++++++++++++++++++++++			
5-00 ed with tygiene other be Me	17. Father's Name (First, Middle, Last)	Con		First, Middle, Ma		truction			
1215 lbe filt ental H arked vent, 1	William Cuthber				s Hislop				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 13a or 28a-f sho injury or other traumatit event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) Neil D. Cuthbert - Brother		Address (Street and Number or		•				
e, M and 2 Health item 2	20a. Method of Disposition	20b. Place of Disposition			20c. Location - City or				
Baltimore, semit. Pages 1 at Department of Hee Important: If ite njury or other tr	1 Burial 2 X Cremation 3 Removal from Sta 4 Donation 5 Other Specify:		r place) 1 Crematory 05	128/2010	Brontwood	Maruland			
altii mit. J partm poora jury o	21. Signature of Funeral Service Cloensee Ho #1070	22 Nar	me and Address of Facility HLV						
	23a. Part I. Enter the disease, or complications that caused	_ ~ 1180	0 New Hampshire			ng, MD20904 Approximate Interval			
Physician /Medical	failure. List only one cause on each line.			rrespiratory arres	t, snock, or neart	Between Onset and Death			
Examiner	Immediate Cause (Final disease a. Pneumocc or condition resulting in death) Due to (or as a conse	ocal pneumon equence of):	1a						
-	Sequentially list conditions, if any, leading to immediate	action co of):							
Raminer	cause. Enter Underlying Cause (Disease or injury that initiated								
Example 15 d	events resulting in death) Last Due to (or as a conse	equence of):							
Box 68760, the death certificate be executed by the attending physician and aled for use as the burial - transit Physician/Medical Exe		er ME g904 6	/19/10 TT						
760, icate by physic the but	23c. If yes, outcom	ne of pregnancy			23d. Date of delivery				
ox 6876 eath certificate attending phy for use as the I	past 12 months? 4 Pregnant at	time of death	death 3Ectopic pregna r (Specify)	ancy	Month D	ay Year			
D. BO) The death by the att sched for Physi	1 Yes 2 No 9 Unknown 9 Unknown	_							
P.O.	Part II. Other significant conditions contributing to death	i but not resulting in the und	derlying cause given in Part I.		acco use contribute to the 2 No 3 Proba	_			
Records, The law requires ficate has been signage 2 should be Completed				24a. Was an	24b. Were auto	opsy findings available			
Division of Vital Records, tal or Attending Physician: The law require rs after death. The law certificate has been sisted in by the funeral director, page 2 should bertification: To Be Completed		<u>-</u>		autopsy perform 1 ✓ Yes 2	ed? death?	ompletion of cause of			
Vital Recystician: The philos certificate director, page	25. Was case referred to medical		26.Place of Death (Check		No 1 ✓ Yes	3 2 No			
Physici Physici or this co	examiner? 1 V Yes 2 No Hospital: 1 Inpatien				esidence 6 Other:				
n of \ iding Pb h. After tl e funeral	27. Manner of Death 1 X Natural 5 Pending	ry 28b. Time of Inju	ry 28c. Injury at Work?	28d. Describe how	w injury occurred				
Division o spital or Attending rours after death. The filled in by the fune certification:	eet and Number or Rur	al Route Number, City							
Div pital or purs aft ceral Di	b de 5 E S E S Suicide 6 Could not be determined (Specify)								
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in bedical Certific	29a. Certifier 1 CertifyIng Physician: To the best of my one) A Medical Examiner: On the basis of exam								
To the Ho To the Fo To the Fo completed	one) 2 Medical Examiner: On the basis of exam and manner stated 29b. Signature and title of certifier	mination and/or investigation	29c. License number		d place, and due to the 29d. Date signed (Mon				
3-Penil =	anots _		O.C.M.E.		May 19, 2010	ur, vaj, rearj			
	30. Name and address of person who completed cause of de	eath (Item 23a)			-	-			
	Ana Rubio MD. Assistant Medical Exam		eet, Baltimore, MD 2120	l					
State Registrar	31. Date filed (Month, Day) earl 2010 \$2. Registrar	's Signature							

OCME

10-03540 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Raymond Chester State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Da May 7, 2010 Medical Examiner 1549 hrs ono 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Dorchester General Hospital Dorchester Cambridge 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Days Hours Min. 213-42-1020 1 🗸 M Country Mary land Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once. 1 Yes 2 No Director 10g. Citizen of What Country? 26 Sland Road 5A 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married White, etc. 1 Yes 2 1 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: ac ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 J M 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) Be eon Mary -rene 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, &ity or Town, State, Zip Code) Ave. 16 nden dae 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 | Burial 2 | Cremation 3 Removal from State 5/10 partment o Meekins Neck Cometer Houpers Island, MD 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Far lity HOME, P. Henry Funeral H 510 Washington ambrida MD. 2/4/3 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as calculate or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ed for use as the burial - transit Physician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Cirrhosis of the Liver Completed been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed death? Yes 2 V No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 PR/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 V Yes 2 No After 1 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 V Natural Pending 1 Yes 2 No To the Funeral Director: filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined 4 Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical one) 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b, Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

OCME 2006

State

30. Name and address of person who completed cause of death (Item 23a)

Victor Weedn MD JD

31. Date filed (Month, Day, Year)

00

Assistant Medical Examiner

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

May 13, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 4:30p M 21 Joyce Marie Caleb 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Manokin Manor nncess comerset 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2 🕅 F 212-52-7601 May 9, Director 63 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at Director 1 X Yes 2 □ No Maryland Somerset Princess Anne 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 11974 Edgehill Terrace Road by Funeral 21853 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or is any light yor other traumatte event, the Maritime 1006. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Sartin ပ Nona Loveless 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann M. Ross/Daughter 32721 Perryhawkin Road, Princess Anne, MD 21853 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 26. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bethel Cemetery 2010 Chesapeake City, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Demenha disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Olsease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Box 68760. IF FEMALE: After this certificate has been signed by the attendin funeral director, page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: A Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Panha Nalm 005/359 May 24/5 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. USHA NATESAN, 1415-5. DIVISION ST SALISBURY, MD 21804

DHMH 17 Rev 1/2001

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State

Registrar

31. Date filed (Month, Day, Year)

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Lake

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Flora L, Cachran 10:22 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Maryland Medical Center Baltimore Cit 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 / 1 0 / 1 9 6 1 1 🗆 M 2 🔽 F 48 217-82-9454 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director MD Harford Edgewood 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21040 9 Carroll Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Own Home Homemaker should be filed with and Mental Hygier 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Grace V. Gibbs William Holloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Inportant: If item 27 is any injury or others. Carroll Avenue, Edgewood, MD 21040 Mary L. Cochran/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Welcome Home Cem. 5/24/2010 Bel Air, MD 4 Donation 5 Other (Specify) Signature of Janetal Service 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA17314 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nticemia Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events and -tran resulting in death) Last Due to (or as a consequence of): sician a Physician/Medical Box 68760 phys nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Barre Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s death? 1 🗌 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 1 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) PZ3080 18, 2010 Patrick Timothy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phelan. Universit Greene

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Armando Victoriano Dimalanta May 2010 6, 4:20 p^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 1 M 2 D F **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Days Hours (Month, Day, Year) SEP 21, 1938 Philippines Yrs Director 545-71-2664 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at. 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2X No Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18725 Curry Powder Lane 20874 Philippines 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Business Consultant Manufacturing / Retail permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Amado Dimalanta UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18725 Curry Powder La., Germantown, MD 20874 Amelia L. Dimalanta / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/10/2010 Atlantic Crematory Glen Burnie, MD 21. Signature of Inéral Service Licensee 22. Name and Address of Facility Thibadeau Mortuary Service, p.a. we M00956 Park Avenue, Gaithersburg, and 1. Eight the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) SUBDURAL HEMORRHAGE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, executed the attending physician and ned for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year s been signed by the s should be detached 1 ☐ Yes 2 L 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ACUTE RENAL FAILURE, MYOCARDIAL INFARCTION, 1 Yes 2 No 3 Probably 4 X Unknown After this certificate has been PNEUMONIA, CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 prior to death? performed? 1 Yes 2 No Yes 2 X No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 \(\bar{\text{Y}} \) Yes Hospital 2 No Other: ျပ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Autonomy, within 24 hours after death, To the Funeral Director; Aft 1 Natural 2 Accident 5 Pendina UNK work 04/13/2010 1 Yes 2X No FELL ON WAY TO BATHROOM Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office ^{28f.} Location (Street and North of Paral Fourth North of ER LA., GERMANTOWN. MD 20874 4 Homicide determined HOME, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number Iduas le 000 68080 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE MD 20850 SIRECSHA JALLZ MD 9901 MEDICAL CENTER DRIVE

Registrar

31. Date filed (Month, Day,

MAY

Year)

14

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MAY 2010 25 10:35 A M ANNA D. DODDS 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APR 28 1916 9. Birthplace (State or Foreign 1 □ M 2 🙀 F Months Days Hours Min. MARYLAND 94 214-07-4222 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No ALLEGANY CUMBERLAND MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. 13529 McMULLEN HWY 21502 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 CELANESE 1. GRANTS FACTORY CASHIER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANNIE (ARTZ) DREW ALFRED E. DREW 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) COLETTE SUDER DAUGHTER 14150 GLEN OAKS DRIVE, CUMBERLAND, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State SUNSET MEMORIAL PARK MAY 28,2010 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAFER FUNERAL SERVICE, 1302 NATIONAL HWY., LAVALE, MD 23a. Partil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ORONAN disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, led ling to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

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23a

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and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health at
Important; if item 27 is
any injury or other trau

Pages 1 and 2 should be in nent of Health and Mental

death with ò

filed within 72 hours after

Baltimore, Maryland 21215-0036

event, the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

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burlal-transi and attending physician for use as the burla Physician/Medical the detached signed by t , page 2 should Completed has certificate Be Certification: To After this funeral

Hospital or Attending Physiclan; The law requires that the death certificate be executed 24 hours after death.

24 hours after death e Funeral Director: filled in by the

To the within 2

P.O. Box 68760

Records,

Division of Vital

Examiner

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Medical

IF FEMALE:

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Loknown 24a. Was an

2010

autopsy 1 ☐ Yes 2 1 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 100 27. Manner of Death 1-Natural

5 Pending investigation 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year)

4 ☐ Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury at Work? 1 ☐ Yes 2 ☐ No

Other:

021244

28d. Describe how injury occurred

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who compléted cause of death (Item 23a) (Type, Print)

JESUS H. TAN, MD, 4 BROADWAY, FROSTBURG, MD 21532

State Registrar 32. Pegistrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05704/2010 CALLIE OLIVIA DIGGS 10:40 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gladys Spellman Specialty Hospital Cheverly Prince Georg's If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 Hours Min 11/16/1930 Director 218-30-4269 79 MD Usual Residence of Decedent or 28a-f shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD Prince George's Upper Marlboro 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10808 Joyceton Drive 20774 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced "natural", Specify. Black Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical sonce." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Assistant <u>Administrative</u> Waste Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Gilbert Matthews Minerva Selby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgie Thomas - daughter 10808 Joyceton Drive, Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cempter) crematory or other place, 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 Donation 5 Other (Specify) Ash/Memorial Cem. 5/11/10 Sandy Spring, MD Signatur of Juneral Service Licer 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 hons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part 1. Enter the disease or complica Interval Between Onset and Death shock, or heart failure. Ust only one Immediate Cause (Final Physician Arrhythmia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi Pneumonia that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical COPD Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
1 Second at time of death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant 9 Unknown 9 Unknown has been signed by e 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VDRF Dependent Respiratory Failure 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Atrial Fibrillation autopsy performed? Yes 2 certificate End State Renal Disease Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2X No မှ 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) After this completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) D27577 and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Ophnell Cumberbatch

14 2010

31. Date filed (Month, Day, Year)

3001 Hospital Drive, Cheverly, MD 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 05/106 2010 ear 1455p M Etlo Raymond Enrico Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Examiner Prince Frederick Burnett Hospice House Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)

MN **Funeral** 1XXM 2 □ F Days 1272571914 MN 470-09-4965 95 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show incal Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f sho ury or other traumatic event, the Me Ical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Laurel 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12901 Bentley Grove Place 20708 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Amarried Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Law Enforcement Career Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernesta Navarro Anthony Enrico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8540 Willd Game Lane, Owings, MD 20736 Ray Enrico/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lee Crematory 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 05/18/2010 Clinton, MD 4 Donation 5 Other (Specify) ^{22. Name and Address of Facility} Lee Funeral Home Calvert, P.A. 8125 Southern Md Blvd., Owings, MD 20736 21. Signatury of Funeral Service Licensee Lisa M Mounts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Due to If as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due the ras a consequence of Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy Live Birth 2 Live Fela Good in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Year 5 Other (specify) Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospica Louis 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Do the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 K Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier R134720 of person who completed cause of death (Item 23a) (Type, Print) & Merrimac 93. 31. Date filed (Month, Day, 32. Registra Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Year May 2Ö10 MINA AVALON 11:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Nursing Home Salisbury Wicomico Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days May 18, 1922 Months Hours 1 ☐ M 2 💢 F Marviland **Director** 87 -82-6298 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Ewell Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21824 4032 Tyler Road USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Yes 2 No Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2X No White Specify: Completed 3 X Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Willis Evans Myrtle Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5534 E. Nithsdale Drive - Salisbury, MD 21801 R. Chelton Evans (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 15 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ewell Church Cemetery May 19,2010 Ewell, Maryland Mary Beth Bradshaw 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME - Crisfield, MD 21817 306 W. Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, EMENT disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examine Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 No 1 Yes funeral director, 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation completed filled in by the Suicide Could not be 28e. Place of İnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 □ only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated title of certifier 29b. Signature 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa M.D. 910 Easternshore Dr Salisbury 21804

State Registrar 31. Date filed (Month, Day, Year)

egistrar's Signatur

		1 State	/ Department of Health and Me Certificate of Death		
	-	Registrar 1. Decedent's Name (First, Middle, Last)		Reg. No 2. Date of Death	o. 3. Time of Death
Physic /Med		Arthur Deen Eckhof		Month Da	
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	40	c. County of Death
		NMS Hell th Carl 5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Nashing 10n
Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last</i> 437−38−2889 1. ★ 2□ F 86	Vrs Months Days Hours Min.	(Month, Day, Year, Sept. 18,1	9. Biktholace (State or Foreign Country) 1923 South Dakota
70		Usual Residence of Decedent			
lanylar show	5	10a. State 10b. County 10c. City, T	Fown or Location Cascade		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the N 28a-f notifie	Director	10e. Street and Number	10f. Zip Code	10g. Ci	itizen of What Country?
h with 23a or st be		P.O. Box 532	21719		U.S.A.
filed within 72 hours after death with the Maryland Hygiene. Whysene. Inter than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? WWT.I	13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
rs afte	by Fi	1 Never Married 2 Married 1 NYes 2 No Koreā	n 1 ☐ Yes 2 ☑ No Specify:		Specify: White
2 hou latura			16a. Decedent's Usual Occupation		Kind of Business/Industry
ithin 7 ne. nan "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of workin life. DO NOT use retired)	ng	
iled w Hygier ther th		17. Father's Name (First, Middle, Last)	Engineer	(First, Middle, Maide	Construction
id be f ental i ked of	To Be	Fred Eckhoff		Mary Eckho	· ·
shou and M s mar	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural	l Route Number, City	or Town, State, Zip Code)
and 2 ealth an 27 i			P.O. Box 532 Cascade,		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show yinjury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Bunal 2 🛣 Cremation 3 ☐ Removal from State cem	netery, crematory or other place) May	25.	Location - City or Town, State
nit. Pa artmer ortant: injury		4 □ Donation 5 □ Other (Specify) Smlt 21. Signature of Funeral Service Licensee	chsburg Crematory 2019		nithsburg, Maryland
permi Depar Impor any ir		Jella La Davis	114 12525 Bradbury Ave.		is Funeral Home
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Physician	_	Immediate Cause (Final disease or condition resulting in death)	ia		Onset and Death
/Medical Examiner		Due to (or as a consequer	loe of):	210 10	(0
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xecuted and Il-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
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The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	IN/M	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2 □ Fetal december 10 programs			23d. Date of delivery
e deat he atte	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of deat			Month Day Year
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aw requires been size should to	Completed			24a. Was an	24b. Were autopsy findings available
The lav	mo;			autopsy performed? 1 Yes 2 X N	
rysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		
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To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle check of the control of the co	edge, death occurred at the time, date and place, a n and/or investigation, in my opinion, death occurr	and due to the cause(red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To the within To the	Me	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
		Michelle Gules CR	NP R-118578	5	-24-2010
		30. Name and address of person who completed cause of death (Item 2		ace to	11.0 212//2
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	14 Marsh Pille He	JUSNWA	1111/2/11/4
Regis		MM 0 1 2010 Runs A	bare		

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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For AMEND#7 per FH State State 5/13/2010 AACO HEALIH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ E. Month. toole 331 M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annarolis Anne Arunde1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **№** M 2 🗆 F Days Months Hours Dec 14 1954 % Yrs. 220-60-7544 55 Maryland Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Shady Side 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If tiem 27 is marked other than "natural", or items 23a or limportant: If item 27 is marked other than "natural", or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event, the Madical Examiner must be any injury or other traumatic event. 10g. Citizen of What Country? Funeral 1558 Columbia Beach Rd. 20764 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Xyes 2 No
If Yes, Give
Year or Dates 1974-78 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed 3 Widowed 4 Divorced Specify: **Black** 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 <u>Maintenance Mechanic</u> <u>Naval</u> Academy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph E. Foote Sr Henrietta Crowner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Jones(Sister) 1162 Oak Ave Shady Side, Md. 20764 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Buriat 2 Cremation 3 Removal from State Maryland Veteran 4 ☐ Donation 5 ☐ Other (Specify) 5-14-10 Crownsville, Md. M.Marne R.A. B.S. Sof Pacility Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, md. 21401 13000 M00483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin sician and burial-transit Cause (Disease or linjury that initiated events death certificate be executed Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical guipt I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? ō Month Year Day Pregnant at time of death Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | 23e. Did tobacco use contribute to the cause of death? ģ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s autopsy 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 **1**000 Other: ျ 1 Donpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes ☐ Accident ☐ Suicide 2 No after death

Director: A

d in by the f Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) filled in 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Tpleted f 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within . only one dure and title of certifie 29d. Date signed (Month, Day, Year) MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

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Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Grace E. Fox 9 Medical May 2010 9:45p 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 603 Himes Avenue Apt. Frederick
If Under 1 Year I If Under 24 Hrs <u>Frederick</u> **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months Days Hours Min. (Month, Day, Year) Country)
Maryland Director Yrs 214-10-3083 88 Sept.17 Usual Residence of Decedent 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Frederick Frederick ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a603 Himes Avenue Apt. 21703 United States Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give ö Š 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 'natural", 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) other t Seamstress Textile Be 17. Father's Name (First, Middle, Last) and Mental Fisher is marked of 18. Mother's Name (First, Middle, Maiden Sumame) မ William E. Blank Laura Decker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trau once, Bonnie Neal/ Daughter Shelley Circle, #1C, Frederick, Maryland 21702 Baftimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State /13/2010 4 Donation 5 Other (Specify) Resthaven Memorial Gardens Frederick, Maryland Signature Funeral Sepice 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes P. A. Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician/ Onset and Death Athero Sclerotic Coronary Artery Disease Medical Due to (or as a consequence of) Examiner <u>End Stage Renal Disease</u> Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 To the I within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47951 May 10, 2010 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Sibte

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31. Date filed (Month, Day, Year)

Kazmi,

Avenue, Frederick, Maryland 21701

To11

32. Registrar's Signature

Chause

House

MD 814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day **Physician** 2010 May 12 Ruth Louise Gullion 8:20 P^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dorchester Mallard Bay Center Cambridge 8. Date of Birth (Month, Day, Year) Jan. 10,1937 Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Pennsylvania 1 □ M 2 X F 73 218-34-0350 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or Items 23a or 28a-f show other traumatic event, the Medical Experimen quat be notified at 1 □Yes 2 No Director Maryland Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6704 Pine Top Road 21643 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify. Specify: White 3 Widowed 4 X Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic events. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဝ George David Hannigan Dorothy Pauline Gettle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Gullion/Son 6704 Pine Top Road, Hurlock, Maryland 21643 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Dorchester Memorial Park 5/15/2010 Cambridge, Maryland 21. Sign ture of Furieral Service Lices Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Er for unarrying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 5 ☐ Other (specify) 9 Unknown á signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ tensio Chronic 1 X Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Hospital or Attending Physiclan: The law requires that the death certificate be executed ithin 24 hours after death.

The Funeral Director; Aft

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Bramble lohnson (Month, Day, Year) 2. Registrar's Signature 31. Date filed

Cambridge MO

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State Registrar

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

MAY 17

The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

HO059973

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Patricia L. Greenwald 10 2010 May 2:03 РМ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 13,1938 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 F Days Hours 71 205-32-5721 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Crofton 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1868 Harcourt Ave. 21114 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes _ TNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental Hygienist Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Lenhart Agnes Fendrick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny G. Rollison/Daughter 2759 Price Rd., Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 05/12/2010 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715

Physician /Medical Examin

Physician

/Medical

Examiner

MD

Director

Funeral

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Be Completed

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Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

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	shock, or heart failure. List only	plications that caused the death. Do not enter the one cause on each line.	mode of dying, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. Myscardial R	-upture			Oriset and Death
	Toballing III dealth)	Due to (or a a consequence of):	There			
eř	Sequentially list conditions,	b. Due to (or as a consequence of):	I NOTAL COTO	7		
틆	if any, leaving to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events					
Exa	resulting in death) Last	Due to (or as a consequence of):				
Completed by Physician/Medical Examiner		_d				
√/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deli	verv
sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No		opic pregnancy er <i>(specify)</i>		Month	Day Year
hy	9 ☐ Unknown					
by F	Part II. Other significant conditions of	contributing to death but not resulting in the underly	ring cause given in Part I.			the cause of death?
ted				1 🗆 Yes 2	□ No 3□ Pr	obably 4 YUnknown
ple			<u></u>	24a. Was an autopsy	prior to c	topsy findings available completion of cause of
္ပ်				performed 1 □ Yes 2 □ No	death? 1 ☐ Yes	2 🗆 No
Be	25. Was case referred to medical examiner?			(Check only one)		
	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residence	6 ☐ Other (Spec	cify)
tion:	27. Manner of Death 1 ■ Natura! 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	Work?	28d. Describe how inju	ry occurred	
Medical Certification: To	3 Suicide 6 Could not be determined		actory, office	28f. Location (Street a. City or Town, State	nd Number or Ru e)	ıral Route Number,
lical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	inysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, gation, in my opinion, death occurr	and due to the cause(s red at the time, date an	s) and manner as d place, and due	s stated. to the cause(s)
Mec	29b. Signature and title of certifier	and mailler stated.	29c. License number	29d D	ate signed (Montl	Day Year)
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			00- 50	/ 3	11011	3

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Medical Conter Annapolis MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10, 2010 Year Garcia Manuel May 10:40am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Rockville County of Death
Montgomery Casey House Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

Dom Rep 8. Date of Birth 1 XM 2 □ F (Month, Day, 8 / 2.4 / Months Days Hours 214-82-7503 Director 47 1962 Usual Residence of Decedent 28a-f shov 10a. Sta MD th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, <u>the Medical Exam</u>iner <u>must be notified at</u> 10b. Count with the Maryland Silver Spring Director 10d. Inside City Limits Montgomery 1 Tes 2 No 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1711 Mt.Piscah Road 20903 Dominican Republic Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No 3 Widowed 4 Divorced Specify: Black Year or Dates Dominican Republic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Supermarket Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mariano Antonio Garcia Hilda Herrera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Soraya Garcia/Daughter Health tem 27 6235 N.W.171st Street Miami, Florida 33015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven 5/14/2010 4 Donation 5 Other (Specify Silver Spring, Md 21. Signature of PHITTIP AD SRIMALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final End stage liver disease Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Linconting Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events burial-trai Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No ed by the a g | Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cate has been siç ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: $_{4\ \square\ \text{Nursing Home}\ 5\ \square\ \text{Residence}\ 6\ \ \text{M}\ \text{Other}\ \text{(Specify)}\ hospice}$ 1 ☐ Yes 2 🗓 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛮 Natural 5 Pending Investigation 1 🗌 Yes 2 🗌 No ☐ Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) D.O.0606234 May 10,2010

Registrar

State

31. Date filed (Month, Day, Year)

14

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bindu Joseph D.O. 6001 Muncaster Mill Rd. Rockville, Md 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 4:35pM 2010 Gordon Grantham May 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hill Haven Assisted Living Facilities Adelphi If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Months Days 1**X** M 2□ F 86 Director 260-16-7073 01/24/1924 Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Silver Spring Montaomeru 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 1413 Milestone Drive U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) D.C. Department of Elementary/Secondary (0-12) College (1-4or 5+) Corrections Lieutenant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Ashley Grantham Oueenie Tucker ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1413 Milestone Drive. Silver Spring. Maryland20904 Mabel R. Grantham - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/17/2010 | Silver Spring. MD Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses NO #1070 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician andrec Ytery homa 5 min /Medical Due to (or as a consequence of Due to (or as a consequence of) Herter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hybertennie Carpo Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Hnervsmi 1□ Yes MONASY 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 🔀 No 3□ DOA ို 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 X Natural

Examiner

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Department o Important: If any injury or

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3altimore, Maryland 21215-0036

that the death certificate be executed physician and s the burial-trans as asn atter for u ed by the a s been signed by should be deta has page

P.O.

Division or Vital Records,

Hospital or Attending

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certificate funeral director. this After death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Location (Street and Number or Rural Route Number, City or Town, State)

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Toledo Terraco + BIDZ Hyaltsville Md. (IVEKCVAIDM.D 3311 31. Date filed (Month, Day, Year)

Registrar

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MAY 14 2010

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of I	Marylan		artment tificate			and M	lental Hygi	ene	201	0	6863
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93	rs afte iral", Exan	ed b	3 Widowed 4 X Divorced	If Yes, Give Year or Dates		1	☐ Yes 2	X No	Specify:			Spe	cify: B1	ack	
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Maryland	should be file and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Number,	City or Tow	ın, State, Zij	Code,)
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nor	Page 1 nent of ant: If it		1 🖾 Burial 2 🗆 Cremation		ite C	Place of Dispo emetery, cren	natory or oti	her place	· : :	/15/	2010		ion - City or		
Baltimore,	# 분원들		4 ☐ Donation 5 ☐ Other (S) 21. Signature of Edneral Service Li		Kes	thaven							rick,		
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Division	Atten ir deal sctor; by the	Certificate:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	not be 28e. Place of					100 2 0	-	28f. Location (Str		ımber or Ru	ral Rou	ıte Number,
DΪ	tal or us after al Dira	S C		bullaing,	etc. (Specify					- 1	City or Town	,			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical E	Physician: To the best xaminer: On the basis of	f examinatio	n and/or invest	tigation, in m	ny opinio	n, death oc	curred at	the time, date and	d place, and	d due to the	cause(s	
	o the	Σ	only one) 3 ☐ Certifying 29b. Signature and title of certifier	Nurse Practioner: To t	he best of m	y knowledge, o	death occurr 29c.	ed at the License	time, date number	and plac	e, and due to the	cause(s) an 9d. Date si	d manner as gned (Mont	stated h, Day,	Year)
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			30. Name and address of person v	who completed cause o	f death (Item	23a) (Type, F	Print)	Ω+:	2001	2	altin	مهره	MI	>	Year) 2 20
	_(ℓ Sta	te	Tiffany Mor	32. Regis	strar's Signa	ture	7	J J I		10	4////		1		7.201
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 0110 M AUBREY E. GILBERT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MEMORIAL HOSPITAL AT EASTON **TALBOT** If Under 1 Year 5. Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 5/31/1942 1 🔀 M 2 🗆 F Months Days Hours Min. PENNSYLVANIA Director 212-40-9072 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits In than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No MARYLAND **TALBOT EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 FEDERAL ST., APT. 16 2160I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black. White, etc. Completed by 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha **MORTICIAN FUNERAL SERVICE** and Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Men Important: If item 27 is marke any injury or other traumatic JOHN IRVING BILLINGHAM FRANCES ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY ANN HAMBLETON / SISTER PO BOX 76, BOZMAN, MD 21612 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 5/26/2010 4 Donation 5 Other (Specify) BROAD CREEK METHODIST CEMETERY BOZMAN, MD Signature of Funeral Sor 22. Name and Address of Facility 1 000 CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) neumana Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been simpled. eate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to for as a consequence of): that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 \square Pending injury 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 5/23/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W lear) 31. Date filed (Month.) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Miles Carl 1:52 Greathouse may 19 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min. 228-54-5406 Director 66 entember Virginia Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matfitted at injury or other traumatic event, the Medical Examiner must he matfitted at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Washington Funkstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 206 East Baltimore Street 21734 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black. White, etc Completed by 1 Never Married 2 X Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Welder Steel Fabricator 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruben Greathouse Goldie Mae Greathouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary June Greathouse 206 East Baltimore Street, Funkstown, Md 21734 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Rose Hill Cemetery 1 X Burial 2 Cremation 3 Removal from State 05-22-10 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Andrew K. Coffman Funeral Home, Inc. <u>40 East Antietam Street, Hagerstówn, Md.</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) ongestin Medical Due to (or as consequence of): Examiner diomy Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to forms ain insequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 2 No 9 Unknown 9 Unknown iis certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident 3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WD

32. Registrar's Signature

DHMH 17 Rev 7/2009

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 5-20-2010

AVE. HAGERSTOWN. MJ 21742

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kenne* Robert		1- For State	State	of Maryla		oartment o			Mental H		a Na	201	0 1686
Physicia	an/	Registrar 1. Decedent's Name (First,		•						2. Date of Deat Month	eg. No. h Day	Year	3. Time of Death
Medical Exami	ner	Kenneth 4a. Facility Name (if not ins	Rob		Holland		4h Cib	v Tour asla	cation of Death	May 10, 2	010 <u> </u>	County of Dea	1315 hrs
		4036 Redden Roa	_	s street and no	inber)			comoke Cit				orcester	aut
Funeral		5. Social Security Number	6. Se	x		s. last birthday)			If Under 24Hrs	_		D/YYYY) 9. E	Birthplace (State or
Director		217-92-5167	1 X	M 2 F	32	Yrs		nths Days	Hours Min	05/23	/197	7	eign Manyland
any		Usual Residence of Deceder 10a. State 10b. Co			10c. Ci	ty, Town or Locat	ion						10d. Inside City Limits
and show	5	Maryland Wo	rcest	er	F	ocomoke	Cit	ty					1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 4038 Redden	Road				10f. 2	Zip Code 21851		10	_	n of What Co USA	ountry?
ath with	Funeral	11. Marital Status 1 X Never Married 2	Married	12. Was Dec	cedent Ever in orces?				nic Origin? (S _i fexican, Puerto	pecity Yes or No- Rican, etc.)	14	4. Race - Am White, etc.	erican Indian, Black,
Rer des		3 Widowed 4		1 X Yes If Yes, Give Yea	²∐ No r Navv	1	Yes	2X No s	specify:		s	oecify:	white
natura	ed by	15. Decedent's Education	(Specify on	ly highest grad	de completed)				(Give kind of v		16b. Kin	d of Busines	s/Industry
36 ain 72 l	ompleted	Elementary/Secondary (0	-12)	College (1	-4 or 5+)	labore		nonang me.	01101 25014			intena	220
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Sol	17. Father's Name (First, Mi	ddle, Last)				- L	18.	Mother's Name	(First, Middle, N			ince
2121! uld be fill Mental F marked	Be	Kenneth Lee								Sales			
MD 2 d 2 shoul Ith and M n 27 is m	9	19a. Informant's Name/Rela Kenneth L.			her					Rural Route Num			
Fe, N I and I Health Fitem	ı	20a. Method of Disposition 1 X Burial 2 Crem			20b	. Place of Dispos	ition (N	lame of cemet		Date			or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other 21. Signature of Fungral Se	er S <i>pecify</i> :		om State GC	crematory or of podwill h Cemetery				15/2010			City, MD
P P P P P P P P P P P P P P P P P P P		Muhal	AL	Deux	1								Association 351
Physician /Medical		23a. Part I. Enter the diseas failure. List only one c	ause on ead	ch line.			ne mod	de of dying, suc	ch as cardiac o	r respiratory arre	st, shock	, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final dis or condition resulting in dea		Contact Sh Due to (or as a		ind of Head				_			Death
		Sequentially list conditions,	b										
	Examiner	if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initial	ause	Oue to (or as a	consequence	of):							
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iO, e be executed ysician and burial - transit	dical	UNPENDED		AMENDED									
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Box 6876 e death certificate the attending phy ed for use as the b	sician/M	past 12 months?	. III ti le	1 Live b	irth ant at time of o	death -	tal deat her (S)		Ectopic pregna	incy	M	onth	Day Year
s, P.O. Box Jires that the death signed by the attent d be detached for the	Physi	1 Yes 2 No 9	Unknown	9 Unkno									
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ords, w require s been sig	Completed	-								24a. Was a	in	24b. Were	autopsy findings available
Recor The law icate has I	ğ							_		autops perfor	ned?	death?	
tal Re(sian: The certificate	0	25. Was case referred to me	dical						Death (Check		. No	1 🗸	Yes 2 No
f Vital Physician: r this certif		examiner? 1 Yes 2 No			npatient 2	ER/Outpatient		,				e 6 🗸 Oth	er: Scene
Division of Vital Records, P.O tal or attending Physician: The law requires that trs after death. *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be deaa	ion:		Pending	FOUND:	Day Year)	28b. Time of It	njury	28c. Injury a		28d. Describe h Subject shot		occurred	
Visic or Atte fter dez Sirecto	Certification:		Investigatio Could not b	28e Place		1300 hrs home, farm, stree	et, facto	ory, office build	ling, etc.			Number or F	Rural Route Number, City
Divi: Hospital or A 24 hours after Funeral Dire	Cert	4 Homicide	determined	1	Single Fa	mily Home				or Town, St 4036 Redden	ate) Road, P	ocomoke C	City, MD
Division of Vital Records, P.O. Box 68761 To the Hospital or Atlanding Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	one) 2 Medical	Examiner.		of examination	edge, death occur and/or investigat	ion, in r	my opinion, de	eath occurred a				
	Σ	29b signature and title of ce	ertifier				2	29c. License n O.C.M.E				te signed (N 1, 2010	fonth, Day, Year)
	-	30. Name and address of pe	rson who	ompleted caus	e of death (Ite	m 23a)		J. J. IVI. I			iviay I	1, 2010	
DA 211		Laron Locke MD	Assista	ant Medica	l Examiner	111 Penn	Stree	et, Baltimo	re, MD 212	01			·
Sta Regist		31. Date filed (Month, Day, Y		32. Re	of tracs Signa	iture A. A.	and.	J					
DHMH 17 Rev 1/20	001	••••	m 64	10		ORIGINA							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2<u>010</u> Physician/ Month Mau 10:00a M Marvin E. Hurwitz 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 **X** M 2 □ F 01/03/1933 New Jersey Director 136-22-8796 77 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12801 Broadmore Road 20904 u.s.A. 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☑ Yes 2 ☐ No Konean
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 X Divorced Caucasian Year or Dates. Conflict any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Antique Dealer Antiques Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Isadore Rubin Hurwitz Jean Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Dana L. Hurwitz - Daughter 6562 9th Street, Chesapeake Beach, Maryland 20732 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State Lincoln Crematory 05/13/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, <u>1800 New Hampshire Ave., Silver Spring, MD 20904</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Septic Shock disease or condition Medical resulting in death) Examiner Severe Hypotension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Examin Cause (Disease or linjury that initiated events Abdominal Infection Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Pregnant at time of death Vas 2 No 9 Unknown 9 Unknown P.0. signed by it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 🔼 No 2 🗆 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 X No 1 Yes မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death To the Hospital or Attending Pleath.
within 24 hours after death.
To the Funeral Director: After the completed filled in by the funeral 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,

Nabilla Khan,

14

31. Date filed (Month, Day, Year)

D63505

1500 Forest Glen Road, Silver Spring, Maryland 20910

May 10, 2010

1	0-03506	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

David Jur	ney Hu		1- For State	tate of Maryla		artment o			Mental H			2.0	10	1686
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Medical			David H	utchison						Month May 6, 20	Day 010	Year		1015 hrs
			4a. Facility Name (if not institut		umber)				ocation of Deat	h		c. County of		
			10625 Mattaponi Ros		7 0	1	Upper I			In B		Prince Ge		
	neral ector		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under Months	1 Year Days	If Under 24Hr Hours Mir	2		1		place (State or New
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	any	ŀ	Usual Residence of Decedent 10a. State 10b. County	/	10c. City	y, Town or Locat	ion		·				1	0d. Inside City Limits
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arylar	8a-fs	Director	10e. Street and Number	ee dedige	з горр	CI HAII	10f. Zip C	ode			10g. Cit	tizen of What	t Countr	y?
the M	a or 2 tiffed	ä	10625 Mattapor	ni Road			2077	72			USA			
with	or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U		s Decedent	of Hispa	anic Ongin? (S	Specify Yes or N	_	14. Race -		an Indian, Black,
death	or ite	اڃ	1 Never Married 2 N	1 X Yes	2 No	II Y			Mexican, Puert	o Rican, etc.)		White,	etc.	
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5-0036 Iled within 7	ygien other he M	5	17. Father's Name (First, Middle			Traine		18	.Mother's Nam	e (First, Middle,			alli	IIIg
21215 Suld be file	rked ent, t	Be	Louis Settle	Hutchison				7	Virgini	a Journ	У			
21 hould	is ma		19a. Informant's Name/Relation			19b. Mailing	Address			Rural Route Nu		City or Town,	State, Z	Zip Code)
MD d 2 sho	n 27 m 27 suma		Jennifer Hutcl	nison/Daug						hens, C				
Baltimore,	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the <u>Medical Examiner must be notified at once</u>		20a. Method of Disposition 1 Burial 2 X Crematic	on 3 Removal fr		Place of Dispos crematory or other		of ceme	etery,	Date	20c.	Location - C	ity or To	own, State
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_	ician	-	23a. Part f. Enter the disease, of	or complications that c	aused the death	Fa n. Do not enter t	IIs Ch	nurc.	h VA an ich as cardiac	nd Annap or respiratory ar	oli rest. sh	s MD ock or heart	E	Approximate Interval
/Me	dical		failure. List only one caus	e on each line.				,			·		1	Between Onset and Death
Exar	niner	- 1	Immediate Cause (Final diseas or condition resulting in death)		consequence								\rightarrow	
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		<u>=</u>	if any, leading to immediate cause. Enter Underlying Cause		consequence of	of):								
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, o	sician and burial - tra	edical	UNPENDED	AMENDED							1,50			
6876(certificate	ng phy		IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes,	outcome of preg pirth		tal death	3	Ectopic pregn	ancv	23	d. Date of de Month	elivery Day	y Year
th cert	r use	icia	past 12 months?	4 Pregn	ant at time of d	aath -	her (Specify							,
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Division of Vital Records, P.O.	signed by the	۾	Part II. Other significant cond	tions contributing to	o death but not i	resulting in the u	inderlying ca	ause give	en in Part I.				_	e cause of death?
JS, I quires	s been sig should be	pleted								24a. Was				psy findings available
OOFC law re	2 2	pg								auto		pric		npletion of cause of
Re	cate	Com			_					1 Yes	2 🗸 N		Yes	2 No
ital	his certifi director,	a	25. Was case referred to medic examiner?	Hospital:	Inpatient 2	ER/Outpatient		_	Death (Check		Poside	ence 6 🗸	Othor: S	`nono
of V	After this funeral dire	٩ ا	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of I			at Work?	28d. Describe				
O Co	ath.	ertification:		May 6, 2	2010 Year)	0000 hrs	1	Yes	3 2 🗸 No	Subject sho	ot self			
Visi	ours after death leral Director: filled in by the	ijca I		estigation 28e. Plac	e of Injury - At h	nome, farm, stree	et, factory, of	ffice buil	ding, etc.			and Number	or Rural	Route Number, City
Dital O	eral I	Cert			Single Far	mily				or Town, 10625 Matta		oad, Upper	Maribo	oro, MD
Division of Vital Records, P.O. Box 6876(within 24 hours after death To the Funeral Director: completely filled in by the			Physician: To the bes	-	-								
Toth	To th	Medical	2 Medical Ex 29b. Signature and title of certif	aminer: On the basis of and manner s		and/or investigat				at the time, date				
1		Σ	255. Oiginature and title of Certif	111	K - /	10		icense r D.C.M.			1	Date signed y 7, 2010	(WONTh	i, ∪ay, rear)
'		-	30. Name and address of perso	UUU		n 23al	-	1 1 1 .			I wid	, ,, 2010		
			Zabiullah Ali, M.D.	Assistant Medic		,	n Street,	Baltim	ore, MD 21	1201				
	St	ate	31. Date filed (Month, Day, Year	1070 LO	egistrar's Sign	ure have	1							
	Regist	rar	MAY 14	LUIU LENGE	who po	19								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8:50 P M Dav Month 201^{Year} **Physician** 13, Leonard N. Hopkins May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Caroline Home for Hospice Caroline Denton 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) 1930 Min. Months Hours 1 □XM 2 □ F 80 220-26-2151 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Preston Director MD Caroline 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21655 22281 Hog Creek Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1 4 9 − 5 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2**√∐X**No White Specify: þ 3 🔀 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ! Hygiene, other than " Elementary/Secondary (0-12) College (1-4or 5+) Mfg. Safety Production permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important; If item 27 is marked other than any Injury or other traumatic event, the Supervisor (Grad. 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula Perry Charles Hopkins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4821 Smithville Rd., Federalsburg, MD 21632 19a. Informant's Name/Relationship (Type. Print) Jane Towers/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Preston, Maryland Junior Order Cemetery 05/18/10 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Metastatic esophageal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician; The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) the detached 9 1 Inknown 9 Unknown Ś signed I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Wother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 24 hours after deat Funeral Director; 8 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0005325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lednum Are Preston MD 21655 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HARTHA 3.014M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UMMC 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Hours Marvland 577**-**36-5093 Director 81 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director MD 1 Yes 2 No Caroline Federalsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 204 Sullivans Mills Road States 21632 United 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1 Never Married 2 Married ☐ Yes 2 ☐xNo Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify. Specify: Black 3 ₩ Widowed 4 □ Divorced Completed Year or Dates ortant: If item 27 Is marked other than "natur injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) $\stackrel{\text{Elementary/Seconday (0-12)}}{G \cdot E \cdot D}.$ College (1-4 or 5+) and Mental Hygiene. Quality Control Inspector Maryland Plastics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Julius Littlejohn Iola Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 Is any injury or other trau Glasford B. Hall, Jr./Son 41885 Feldspar Place, Stoneridge, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Federal Hill Cemetery 05/20/10 4 ☐ Donation 5 ☐ Other (Specify) Federalsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. Estern Wichael 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ARTERY aneurysm ERTEBRAL disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): KemoReha arachnoi Caquaintany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 🗌 Yes 2 No 3 Probably 4 W Unknown Completed . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 😾 Yes 1 Inpatient 2 - ER/Outpatient 3 - DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours are To the Funeral Director. After To the Funeral Director. After To the Funeral filled in by the fun 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 19800 2010

Registrar

State

22 South GREENE

84

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

BALA

MIKLOSH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 10 Month 05 CLAS AM Theodore Janey Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 XM 2 | F Days Hours Min. Director Yrs. 218-24-6227 January 8, 1928 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No MD Calvert Saint Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8835 Mackall Road 20685 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No 3 Widowed 4 Divorced Year or Dates. 1946-1947 Specify Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lawrence Janey **Hattie Gross** 19a. Informant's Name/Relationship (Type, Print) . Page 1 and 2 shou tment of Health and tant: If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Janey - son 8835 Mackall Road, Saint Leonard, MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Veterans Cem. May 19, 2010 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Bladys 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ malnutri disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 5 Other (specify) Yes ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown failure 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** funeral director, Be 26. Place of Death (Check only one) 1 🗆 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident 2 🗆 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) leted filled in by Homicide determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatu ပ္ 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robyn Brome, M.D. Point Lookast Rd. Leonardtown, MD 20050 31. Date filed (Month, Day State 32. Registra s Signature Registrar

DHMH 17 Rev 7/2009

JANEY JANEY

HEODORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item I per phys. 6904 6/2/10 dk
State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#30.PerPhys.PCC5-17-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 11:05AM Milton Elijah Medical Jones May 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Civista Medical

5. Social Security Number 6. Sex LaPlata Center Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Days Hours 1 € M 2 □ F Months Wash D.C Director 85 579-30-5242 Usual Residence of Decedent or 28a-f show 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hydiene 10a. State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Charles Waldorf 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20603 U.S.A. 9104 Asworth Court 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. o. þ 1 Never Married 2 Married 1 Yes Give 3altimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced 1956 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Procurement Analyst Dept. of Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Jones Ruth Magruder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trat Joyce Holmes/daughter Asworth Ct. Waldorf, Md. 20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) teran's Cem 5/18/2010 Cheltenham 22. Name and Address of Facility Hodges and Edwards 21. Signature of Funeral Service Licensee Silver Hill Rd. Suitland, Md. 20746 Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ebock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any leading to immedia cause. Enter Underlying physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \square No 3 \square Probably 4 \swarrow Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? 1 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 🗌 Yes 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 1 Natural 5 Pending 2 🗌 No Accident Suicide Investigation within 24 hours after death

To the Funeral Director:,
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Continuing Number Practioner: To the best of my knowledge due to the time, date and place and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Dat€ signed (Month, Day, Year))0068232~ 901 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. EJIDGUMIE

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day,

2010

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	Clair of 1	viaryiari		tificat		eath	-	Reg. No.	2011	1 68/3
		ž.	1. Decedent's Name (First, Midd	e, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Irene	Hasti	ings		J	enkir	ıs	5	11	2010	23:30 M
*	Examin	_	4a. Facility Name (If not institutio				4b. City,	Town, or L	ocation of Death		4c. C	county of Deat	a
			Harrison Senior	Living of	Snow	Hill	Sno	w Hil	1			Worce	ster
	Funeral Director		5. Social Security Number 221–10–8524	6. Sex 7. 1 ☐ M 2 ∑ F	Age (In yrs. 89	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 9-15-	ay, Year)		hplace (State or Foreign untry) aryland
pud	M and	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
As IV	f show	o		ester		Ocean	Cita						1X Yes 2 No
art a	28a-	Director	10e. Street and Number	ester		Ocean	10f. Zip				10g. Citize	en of What Co	untry?
with	3a or		313 Tuna Lane					21	842		US	Δ	
402	ms 2	Funeral	11. Marital Status	12. Was Decede	nt Ever in U	.S. 13.\	Was Dece		panic Origin? (Sp , Mexican, Puerto	ecify Yes or No		4. Race - Ame Black, White	
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9 %	natur lical I	sted	15. Deceder	nt's Education est grade completed)		16a. Deced	dent's Usu	al Occupat	ion ring most of work	ina	16b. Kin	d of Business/	Industry
ithin	nan "i	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	1			ring most of work	9		. 1	
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1 of 1	snould be med and Mental Hygi is marked other aumatic event, t	Be		Lasij	11		_	- 1		c (1 1101, 1111daio	, maidoir c		llis
y y	mark matic	은	Joseph 19a. Informant's Name/Relation:	ship (Type Print)	п	asting:			Mae nd Number or Rui	ral Route Numb	per. City or		
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	rages I and z ment of Health a ant: If Item 27 is ury or other tra		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (3 □Removal from Sta Specify)	ite	loam C	-		1	2-2010	Sil	oam. Ma	aryland
	permit. Pages I and Department of Heal important: If Item 2 any injury or other once.		21. Signature of Funeral Service		Jako	22	2. Name ar	nd Address	of Facility	Bounds	Funer	al Home	2
9.			23a Part Enter the disease of	r complications that cau	sed the deat							Maryla	and 21804 Approximate
E	- 2		23a. Party. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final			A				, , , ,			Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. CORON	as a consec	ARTE	RY	DISE	ASE			-	
Ę	Examiner				uo u 0011000	(401100 01)1						1	
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5,00	ian a	Ë	resulting in death) Last	Due to (or	as a consec	quence of):							
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	ding parse as	sician/Medical	IF FEMALE:	23c. If yes, outco	me of prean	ancv					,	3d. Date of de	livery
בר ביים ביים ביים ביים ביים ביים ביים בי	atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birt 4 ☐ Pregnar	h 2 ☐ Feta	al death 3[⊒Ectopic p ⊒ Other (s					Month	Day Year
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The law requires that the death	s mar ned b deta	y Phy	Part II. Other significant condit	ions contributing to deat	h but not res	sulting in the u	nderlying o	cause give	n in Part I.	23e. Did	tobacco us	se contribute to	o the cause of death?
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ב קר	Ine is	mo									opsy formed? 2 No	death?	
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· ·	nis ce	To B	1 Yes 2 No	Hospital: 1 ☐ Ing	atient 2] ER/Outpatier	nt 3 □ D	Othe	1: 4 Nursing H	ome 5□Res	sidence 6	☐Other (Spe	ecify)
	ng Pl		27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date of (Month,	Injury <i>Day Year)</i>	28b. Time o		28c. Injury Work		28d. Describe	how injury	occurred /	
מוא	Attending r death. ector: After by the fune	cati	2 Accident invest	igation			M		es 2 □ No	006	(044	d Alexander a series E	hum I Davida Mumbar
UNISION ior Attending	after d after d i Direc d in by	Certification:	4 ☐ Homicide deter	minod 200. Flace U	, etc. <i>(Spe</i> c	nome, farm, sti ify)	reet, tactor	у, опісе		City or To	own, State)))	lural Route Number,
Hoopita	To the Hospital or Artending Prystotan: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Medical C		ng Physician: To the b I Examiner: On the bas and manne	is of examin								
o qq	o the omple	Mec	29b. Signature and title of certific				29	c. License	number			e signed (Mon	
P	1) Sh	My MI)				D 00	62172		51	12/20	10
/	L'A		30. Name and address of perso	n who completed cause	of death (Ite	m 23a) (Type,	Print)						
	~			ATYAL, MD	1601	MANK	ET G	- 0.	COMOKE	COTY	MD:	21851	
	5		OTHICKD IC O	יו אנן בור דור	ist ar's Sign	MILIER	E1 3	PO	COMORE	U 17		7031	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 6:00 AM Henry 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore County HOME Lutheran If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreight Country) 5. Social Security Number 7. Age (In yrs. last birthdav) **Funeral** Year 1 M 2 F Months Days 219-32-4609 Director Marylawo eh.2 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evaniner must be notified 1 ☐Yes 2 ☐ No Director Dorchester ambrida 10e. Street and Number 10g, Citizen of What Country? death with 50 Funeral U 5 A nders 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, It was the least traumatic event, It was the least traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Store Ketai 2 17. Father's Name (First, Middle, Last) Be Beat 2 tarry Jackson 19a. Informant's Name/Ref-tionship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave, Cambridge under5 Margaret 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/ 18/10 4 Donation 5 Dother (Specify) 22. Name and Address / Facility vaugh 21. Signature of Funeral Service Licensee Funeral Home, P. A. 510 washington St Cambrid MD. 2 1613 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung disease or condition resulting in death) (GNW /Medical Due to (or as a conseque coof): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has certificate 1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes 2 000 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Hoursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No. Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral of 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending death. investigation 1 🗆 Yes 2 No 2 Accident I Director: d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Raymond 5/12/10 Da7683 mul MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymona Avc Miller Smuh Bulhmore MO

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jones Francis 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Wicomico astal Hospice 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Davs Min. Hours 1 🖾 M 2 🗆 F Months 11/15/1939 70 DeTaware 216-38-9368 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10a. State death with the Maryland Director 1 🗌 Yes 2 🕱 No Salisbury Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21804 items 23a 6273 Walston Switch Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i 1 X Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) construction roofing contractor Be any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris Mildred Jones Francis Toomey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6273 Walston Switch Rd., Salisbury, MD 21804 Shirley Smith/sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/18/2010 Pittsville, MD Pittsville Cemetery 4 Donation 5 Other (Specific . Signature of Funeral Service Liv 22.Nama and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final LUNG CARCINDINA MRTASTATIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any last solutions cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 2 No 1 Yes 2 L been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? HOSPICE 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28b. Time of 27. Manner of eath 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Ratural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Contifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar
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	1	For State Registrar		State of N	ıaryıan	•	artment of t tificate of l	Health and Death	mentai Hy	/gieni Reg. N	-170		0 1007
Physician Medica		1. Decedent's Name (First, Mid Robert K.]	idie, Last, Kline)					2. Date of Do		ay Ye 7 <u>20</u>	ear 10	3. Time of Death 7:46 A M
Examine		4a. Facility Name (if not institute 17586 Oriole		street and number)			4b. City, Town, o	r Location of Deatl	h		c. County of harles		V-011-
Funeral Director		5. Social Security Number 577–38–5898		X 7. A	ge (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi	rth ay, Year)	1931 _B	Birthp	place (State or Foreign try)
and show at	ا ا	Usual Residence of Decedent 10a. State 10b. Cour	-			y, Town or Lo							0d. Inside City Limits
r 28a-f	Director	MD Char	les (County	Cobk) Islan	10f. Zip Code			10a C	Citizen of Wha	at Coun	1 Yes 2 No
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Tree in in in in in in in in in in in in in	ລ	11. Marital Status1 ☐ Never Married 2 ☐ N3 ☒Widowed 4 ☐ Divorce		12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S No	1:	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🌠 No	dispanic Origin? (Span, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	-	14. Race Black, \ Specify:	White, e	etc.
72 hour	Completed	(Specify only high		de completed)		(Give I	lent's Usual Occup kind of work done O NOT use retired	during most of wor	rking	16b.	Kind of Busir	ness Inc	lustry
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Mental Herarked of atic ever	90	17. Father's Name (First, Middle Joseph G. Kl						18. Mother's Nai Floren	me (First, Middle ce Duga:		n Surname)		
and 2 shou Health and tem 27 is m		19a. Informant's Name/Relatio Robert G. Kl						and Number or Ru ceek View					²⁰⁷⁷⁸
Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 4 □ Donation 5 □ Othe			e c	emetery, cren	sition (Name of natory or other place) In Cem.	^{ce)} 05/1	Date 3/2010		Location - Cit		wn, State
permit. F Departm Importa any inju	ŀ	21. Signature of Funeral Service			1	22	. Name and Addre	ess of Facility Be Crain Hwy				5	
	1	23a. Part 1. Enter the disease, shock, or heart failure. Lis		e cause on each li	ne.	h. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory a			\top	Approximate Interval Between Onset and Death
Physician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		a. Olon Due to (or as			15RY	DISEAS	٤.			+	Onset and Beauti
	liner.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	J	b. ————————————————————————————————————	s a consequ	uence of):						+	
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Attending Physician: The law requires that the death certificate be redeath. sctor: After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the bu	~ I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of c	al death 3	Ectopic pregnan Other (specify)	су			23d. Date o Month		ery Day Year
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Physician: this certific al director,	10 De	examiner? 1 Yes 2 No 27. Manner of Death	F			ER/Outpatier	ot 3 DOA Oth	ner: 4 Nursing H	lome 5 Res			Specify)
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To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completed filled in by the fu	Medical	(Check 2 / Medica	al Examin	er: On the basis of	examination	n and/or invest	igation, in my opini	e, date and place, a ion, death occurred ne time, date and pla	at the time, date	and place	e, and due to	the cau	use(s) and manner stated
To the vithing to the company		29b. Signature and title of certi	ifier	M	·		29c. Licens	53885	!	29d. D	ate signed (N	10nth, [
146		30. Name and address of person	who co	ompleted cause of		1 23a) (Type, P	rint)	11 0	y WA	na	rf N	10	20602
State Registrar		31. Date filed (Month, Day, Year MAY 1			rar's Signat		ans						
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Registrar DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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31. Date filed (Month, Day, Year) 8 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#1 per PHY. State State 5/12/10 AACO HEALTH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death James William Lambdin 3. Time of Death Physician/ Month - 20 aum Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death OLUMBIA 10 WARD . Age (In yrs. last birthday) 52 yrs. Funeral If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 XIM 2 □ F Hours Sep. 20, 1957 Middlesboro, KY Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Baltimore City Curtis Bay Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1356 Hollow Glen Court United States 21226 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married Completed by 1 X Yes 2 If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Me Lical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Soldier 12 U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Lambdin Helen M. Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1356 Hollow Glen Court, Curtis Bay, MD 21226 Gina Lambdin / 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 X Removal from State 05/12/2010 | Maryville, TN 4 Donation 5 Other (Specify) Tenn. Crem. Co. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death <Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burialattending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live Birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has l page 2 s autopsy death? this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 🗌 Yes 2 No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death
To the Funeral Director: / 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Humera P. Mujahid 31. Date filed (Mont State Registrar

		,	For State Registrar		State of N	Marylan		artment rtificate				ental Hy	giene Reg. No.	201	0 1687
t		51	1. Decedent's Name (First, N	liddle, Las	t)							2. Date of Do	eath Day	Year	3. Time of Death
61	Physici /Medi		Miles E	veret	t La	wson						May 9,			2:10 PM ^M
	Examir		4a. Facility Name (If not instit	ution, give	street and number	er)		4b. City,	Town, or	Location	of Death		4c. (County of De	ath
2			26594 Deal	Islan	d Road			Princ	cess	Anne	2		S	omerse	t
	Funeral	7	5. Social Security Number	6. Se		Age (In yrs. I		if Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth a <i>y, Year)</i>	9. B	irthplace (State or Foreign Country)
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Σ	r t 2 # d		Lucille Mae	Lawso	n/Mother		2659	4 Deal	l Is	land	Road	, Prin	cess	Anne,	MD 21853
Baltimore,	of Hear		20a. Method of Disposition		D	1 ~	lace of Dispo emetery, cre	osition (Nan	ne of ther plac	e)		ate	20c. Lo	cation - City	or Town, State
Ĕ	Page nent int: if		1 X Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Oth			St.	Pete	rs U.N	4. C	em.	05/1	2/2010	0ri	ole, M	faryland
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	13		30. Name and address of pe	OV.	completed cause	of death (Item	n 23a\ (Turo	Print)							
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1:05A M Raymond Levere Little 25 May 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Loyalton of Hagerstown Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) 18,1907 Pennsylvania 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**火**□ M 2□ F 102 176-07-9731 Director \$eptember Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f show any or other transmy or other transmit be notified at my or other transmit be notified at my or other transmits. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20009 Rosebank Way 21742 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tool Cuter & Grinder Aircraft Mfg. 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edmund Peter Little 2 Alice Virginia Spangler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis L. Little 17008 Sterling Road, Williamsport, Maryland 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important; if any injury or once. 3 Removal from State Rest Haven Cemetery 05-28-10 |Hagerstown, Maryland 21. Signature of Funeral Service Licenses Andrew K. Coffman Funeral Home, inc. R. ho 40 East Antietam Street, Hagerstown, Md. 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician ECAOLS disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 □No 1 ☐ Yes 2 🗖 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Special 1 ☐ Yes 2 E 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier one) 29b. Sign gned (Month, Day, Year)

State Registrar 30. Name and

31. Date filed (Month. Day

Year.

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death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State RegistrarAmend#1.PerPhys.PGC5-17-10crCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ М May 2010 1630 Virgil C Monroe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Holy Cross Hospital Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗽 M 2 🗆 F Days Hours Min Month, Day, Wash. **Director** 579-88-7530 51 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Forestville MD PG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6457 Hil Mar Drive 20747 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Yes 2 No Yes, Give 1 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Pepco injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Monroe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6457 Hil Mar Drive
Forestyj Tar Frances Taliaferro 19a. Informant's Name/Relationship (Type, Print) 457 Hil orestvi Drive Joann Monroe/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 5/17/10 Cemeterv Cheltenham, Md 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd. Suitland, Md. 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Impediate Cause (Final Onset and Death Ph_sician/ Metastatic Lung Cancer disease or condition Medical resulting in death) Examiner Seizure Disorder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 2 No been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Urinary Tract Infection 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyperglycemia has e 2 autopsy r this certificate has performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 12 No Other: ြု 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined E Funeral D leted filled i Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier D41752 man 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mann, 1500 noel Forest State Registrar

			For State Registrar	Sta	te of N	/larylan		artment o rtificate			nd Me	_	giene Reg. No. (011	3 (6882
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	4		30. Name and address of perso	n who complete	ed cause of	death (Item	23a) (Type,	Print)	_	WW			,			
	IVA		JEFFREY R.	SCH EIR	ER.	DO	1051	4 KAC	EIR	ACIL	Ro	AD, BE	ERLIN	mo	218	71
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		For State Registrar			of Maryla	•	artment of F rtificate of L		and IVIE		giene Reg. No.	2010	6883
Physicia		1. Decedent's Name		,						2. Date of Dea 05/08/		Year	3. Time of Death
Medic Examin		4a. Facility Name (if	not institution, g	ive street and num	nber)		4b. City, Town, o	Location o		· · · · ·	4c. C	ounty of Death	1
Funeral Director		5. Social Security N 217-30-4	umber 6	5. Sex 1 □ M 2 🛂 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8 Min.	Date of Bird	<u> </u>	9. Birth	nplace (State or Foreign ntry)
ryland -f show ied at	ctor	Usual Residence of 10a. State	10b. County			City, Town or Lo	cation		· -				10d. Inside City Limits
with the Ma 23a or 28a 1st be notif	Funeral Director	MD 10e. Street and Nur 13240 Hi		 Road	H3	lghland	10f. Zip Code 20777				10g. Citize	en of What Cou	1 X Yes 2 □ No untry?
s after death al", or items Examiner m		11. Marital Status 1 ☐ Never Marr 3 [XWidowed		12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	rces? 2 X No e		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	n, Mexican,	in? (Specif , Puerto Ric	y Yes or No- can, etc.)		I. Race - Ameri Black, White	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	(Spe	15. Decedent ecify only highes			(Give life. D	dent's Usual Occup kind of work done o O NOT use retired)	ation during most	of working	· · · ·		d of Business I	
d be filed wir	To Be (7th 17. Father's Name (Kenneth		L st)		Dome:	Stic		r's Name (f	First, Middle,	Home Maiden Su		
d 2 should alth and N 27 is me		19a. Informant's Na Alda McD		(Type, Print) daughtei	c	1	ng Address (Street Danford						Code)
Page 1 an nent of He ant: If item ıry or othe		20a. Method of Disp 1 X Buria 2 4 Dogation		Removal from	State	cemetery, crer	osition (Name of matory or other place UMC Cem.		Dat			ation - City or I	
permit. Departr Imports any inju		21. Signature of Fu	neral Service Lic	Au	und	22	2. Name and Addre	ss of Facility	Snc	wden I			
Physician/ Medical		23a. Part 1. Enter t shock, or hea Immediate Cause (disease or condition resulting in death)	rt failuje. List on (Final	one cause on ea	ch line.		er the mode of dyir				rest,		Approximate Interval Between Onset and Death
Examiner	ner	Sequentially list co if any, leading to in cause. Enter Unde	onditions,	b. —	or as a conse		•						
e executed cian and urial-transit	al Examiner	cause. Enter Unde Cause (Disease or that initiated event resulting in death)	iinjury s	c	(or as a conse	quence of):							
ificate bing physic	Medical	IF FEMALE:		d							<u> </u>		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Where the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		Birth 2 🗌 Fe nant at time o	etal death 3	Country Countr	Э			23	3d. Date of deli Month	very Day Year
luires that the signed by all de deta		Part II. Other signif		s contributing to d	eath but not re	esulting in the u	underlying cause gi	ven in Part I		23e. Did to			the cause of death?
The law rec ate has bee page 2 sho	Completed by	CHFON		VEY DIS	EASE					24a. Was autoj perfo 1 Yes		prior to c death?	opsy findings available ompletion of cause of
sician: certific irector,	Be	25. Was case referrence examiner? 1 ☐ Yes 2	ed to medical	Hospital:		3	Oth	ace of Deat	,		/		Margare
nding Phys tth. : After this s funeral di	cate: To	27. Manner of Death 1 Natural 2 Accident		28a. Date (Mon		28b. Time of injury	f 28c. Injur	4 <u>U Nu</u> yat	28	e 5 L Resident Reside l		Other (Special	N HOSACE
tal or Atter rs after dea al Director ed in by the	d Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no	ot be 28e. Place	of Injury - At I		reet, factory, office		28	f. Location (S City or Tow		Number or Run	al Route Number,
the Hospi nin 24 hou the Funer: npleted fill	Medical	(Check 2 only one) 3	Medical Ex	lurse Practioner:	sis of examinat To the best of	ion and/or inves my knowledge,	tigation, in my opini death occurred at th	on, death oc e time, date	curred at the and place,	e time, date a and due to th	and place, a e cause(s) a	nd due to the c and manner as	ause(s) and manner stated. stated.
3		29b. Signature and	title of certifier	20)) z	1	29c. Licens	439	5		29d. Date	signed (Month)	, Day, Year) EN O 2,MD ELZCH
		30. Name and addr	ess of person w	no completed caus	se of death (Ite	em 23a) (Type, I 6 70/ N	Print) ICHAPLE	8 ST, 8	WITE	4105	BA	TIMORE	-MD 21204
Stat	te		th, Day, Year)		legistrar's Sigr	nature	while						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			State of Maryland / De State of Maryland / De	partment of Health Certificate of Deatl			ene	110 16884
	Physicia	an	1. Decedent's Name (First, Middle, Last) Mary Ellen McIntyre		2	2. Date of Death Month 0.5		3. Time of Death 2010 12:05 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Holly Place	4b. City, Town, or Location Hagerstown	on of Death	03	4c. County Washi	y of Death
Ī	Funeral Director		5. Social Security Number 168−14−3575 6. Sex 1	(ay) If Under 1 Year If Under Months Days Hours	ler 24 Hrs. s Min.	B. Date of Birth (Month, Day, 07 13	Year) 1922	9. Birthplace (State or Foreign Country) Gettysburg, PA
	aryland show	ř	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or MD Washington Hagers					10d. Inside City Limits 1 □XYes 2 □ No
	r 28a-f	Funeral Director	MD Washington Hagers 1 10e. Street and Number	10f. Zip Code		11	og. Citizen of	What Country?
	23a o	ralD	268 S. Potomac St.	21740		į	US	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Examinar must be invited at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Of If Yes, specify Cuban, Mexication 1 ☐ Yes 2X No Specific No.		ify Yes or No- ican, etc.)	Bla	ace - American Indian, ack, White, etc. White
0-6171	vithin 72 hor ine. han "natur c Medical I	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during m fe. DO NOT use retired)	nost of working			Business/Industry ng home
7 0	filed w Hygie other t		6 diet. 17. Father's Name (First, Middle, Last)	ary aide	other's Name	(First, Middle, N		
10	uld be Mental Irked c	To Be	Wilford Forsythe	Ale	da Sch	uler		
lal)	2 sho h and i 'Is ma raums	ľ		lailing Address (Street and Num 7 Barr Rd。 Gre		Route Number		
ָ ט	Healt Healt tem 2			isposition (Name of	Da	ite		- City or Town, State
	Pages nent of int: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	n Memorial Gar	05/27/ dens	²⁰¹⁰ c	hamber	sburg, PA
סמווו	permit. Departn Imports any inju		21. Signature of Fune al Service License	22. Name and Address of Fac 50 S. Broad St	cility Gr	ove-Bow ynesbor		Funeral Home,Inc 17268
7	Physician /Medical Examiner	niner	23a. Part 1. Envir the disease, or complications that caused the death. Do not shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to himse date cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury)	ive heart	Di	sease		Interval Between Onset and Death
Box 667 bu,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	n/Medical Examiner	Tresulting in death) Last Due to (or as a consequence of) d				23d. D	Date of delivery
, ,	the death by the atter ached for u	hysician/Me	1 Live birth 2 Fetal death 1 Yes 2 1 Yes 2 9 Unknown 1 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			N	Month Day Year
ras, r	equires tha en signed ould be det	ed by P	Part II. Other significant conditions contributing to death but not resulting in the Dewventia, Dia Settle M	he underlying cause given in Pa	art I.	23e. Did to	No.	ontribute to the cause of death? 3 Probably 4 Unknown
al Kecords,	t: The law re icate has be ; page 2 sho	Completed				24a. Was a autope perfor 1 □ Yes	SV	b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
VITAI	/slciar s certif director	o Be	25. Was case referred to medical examiner? 1 Tyes 2 Tyo	Others		(Check only or ne 5 ☐ Resid		Other (Specify) Ruthome
ion or	ending Phy ath. or: After this he funeral o	Certification: To	27 Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 28a. Date of Injury (Month, Day, Year)	me of 28c. Injury at	_ 2	8d. Describe h		
DIVISION	tal or Atters are al Directoried in by the	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	2	8f. Location (S City or Tow	treet and Nur n, State)	mber or Rural Route Number,
	Hospi 24 hou Funer etely fil	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check only one) 2 Medical ExamIner: On the basis of examination and/one) and manner stated.					
	To the within To the compl	Me	29b. Signature and title of certifier	29c. License numb				ned (Month, Day, Year)
			hold bull	Dool	0323	33	5-	24-10
_			30. Name and address of person who completed cause of death (Item 23a) (To 580C Northern Rue Hace	iype, Print)	10	2174	2	
į	Sta Registi		580C Northern Pre Herge 31. Date filed (Month, Day, Year) JUN 01 2010 32. Degistrar's Signature	ball				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Miller Reba 1607 В. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS-RMC Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 PA **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Hours 1 🗆 M 2 🗆 🗶 Oct 14. 1926 215-26-0595 Director 83 Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Mineral Ridgeley 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26753 Rt. 2 Box 522 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 KWidowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) dietician Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Minnie (Morse) Jav Alva Jav 19a. Informant's Name/Relationship (Type, Print)

Marian Clark Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 2 Box 522 Ridgeley WV 26753 daughte 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State Shreves Chapel Cemetery PA Clearville 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Carpe III Fullieral Home, PA any 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ che Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier SUDMEER SANI KOMMI 23/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2500 WILLOWBROOK RO CUMBERLANDIMD SUDHEER SANIKOMMU M.D. 31. Date filed (Month, Day, Year) State JUN 0 1 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State	State of Ma	ryland	•				and M	ental Hy	giene			10006
			Registrar 1. Decedent's Name (First, Middle, Last	£1		Cen	tificate	of D	eatn			Reg. No	6. U I U		6886
	Physicia		Miriam To								2. Date of Dea	ath Da	34 20	اما	3. Time of Death
_	Medic Examin		4a. Facility Name (if not institution, give				4b. City,	Town, or !	ocation o	of Death	<u> </u>	40	c. County of De		12.30
	ZAGITIII	٠.	Coastal Hospice	h 1 D	Lak	e	S	alis	bur	-1			Wico		ico
	Funeral		5. Social Security Number 6. Se			st birthday)	If Under Months	1 Year Days	If Under (I. dim	8. Date of Birt	th v Year)	g, F	Birthpla	ace (State or Foreign
	Director		218-48-6186 11		89	Yrs.	Wiemino	Suje	110010	.,	July 27	7, 1	920 M	ary	land
	show at	5	10a. State 10b. County		10c. City,	, Town or Loc	ation							10	d. Inside City Limits
	Aaryla 8a-f s tified	Director	MD Caroli	ne				Pr	esto	n					1 Yes 2X No
	a or 2	Ö	10e. Street and Number				10f. Zip		2165				itizen of What		
	h with	Funeral	6181 Nagel Road						2165			Un:	ited S	ta	tes
	r iten		11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces?		. 13. W	as Decedo Yes, speci	ent of His ify Cuban	panic Orig , Mexican,	gin? (Spec , Puerto F	ify Yes or No- lican, etc.)		14. Race - Ar Biack, WI		
036	s after al", o Exam	d by	3 X Widowed 4 Divorced	1 ☐ Yes 2x X/N If Yes, Give Year or Dates.	10	1	☐ Yes 2	2 🙀 No	Specify:				Specify:	Wh	ite
> 0	hours natur lical	Completed	15. Decedent's Ed	lucation	-7	16a. Decede	ent's Usua	1 Occupat	tion		_	16b. k	Kind of Busines	s Indu	ıstry
ුර 215	nin 72 ne. han " e Meg	E I	(Specify only highest grades Elementary/Seconday (0-12)	College (1-4 or 5+	-)	life. DC	ind of wor NOT use	retired)	iring most	ot workin	g		0 11		
M) / Ind 213	d with dygien ther t	امها	17. Father's Name (First, Middle, Last)	2		Home	emak						Own Ho	ome	
≥auc	be file antal h ked o c eve	일	Norman H. Todo	1				- 1			(First, Middle, 1 Will		Surname)		
gel, Minam Maryland 21215-0036	nd Me mari		19a. Informant's Name/Relationship (Ty)			19b. Mailine	a Address	(Street ar					r Town, State,	Zin Co	ide)
G Z	d 2 shalth a		David B. Nagel,	Son									ID 216		40,
N^{lpha} Baltimore,	of He of He fiten r oth		20a. Method of Disposition 1 XBurial 2 Cremation 3	Damayal from State		ace of Dispos emetery, crem			,		ate		ocation - City		
∠ <u>Ĕ</u>	. Раде tment tant: I		4 Donation 5 Other (Specify		Hi1	1 Cres	t Cen	neter	у М						, Maryland
Ball	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	Elem		22.	Name and	d Address Mai	of Facility n St.	Fr Fe	amptom derals	Fun burg	eral H	ome 163	P.A.
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused the cause on each line	the death										Approximate nterval Between
7.00	hysician/		Immediate Cause (Final disease or condition		1R	NTI	A								Onset and Death
10	Medical Examiner		resulting in death)	Due to (or as a										1	
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consoque	ance of:								-	
	red nsit	Examiner	cause. Enter Underlying	Due to (or as a	conseque	ence ory.									
	ate be executed hysician and the burial-transit	Exa	that initiated events resulting in death) Last	C. Due to (or as a	conseque	ence of):								\top	
09	e be o	dical		d										\perp	
876	tificat ing ph	Mec	IF FEMALE:			_									
9 ×	eath certificate attending phy I for use as th		23b. Was decedent pregnant in the past 12 pageths?	23c. If yes, outcome of 1 Live Birth 2	☐ Fetal	death 3 🗌	Ectopic p					1	23d. Date of Month		y Day Year
, M	ne dea the a	ysic	1 Yes No	4 ☐ Pregnant at 1 9 ☐ Unknown	time of de	eath 5□	Other (sp	ecity)					WOTE		rear
P.0	that the dea ned by the a detached f	by Pt	Part II. Other significant conditions co	ntributing to death bu	t not resu	ılting in the ur	nderlying c	ause give	n in Part I		23e. Did to	obacco	use contribute	to the	cause of death?
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Rec	The la ate ha	No.									autop perfo 1 Yes	rmed2	death	?	ARO
<u> </u>	sian: ertifica ictor, I		25. Was case referred to medical examiner?						ce of Deat	h (C <i>h</i> eck		7			
Ξ	Physic this o	욘	1 ☐ Yes Z ☐ No 27. Manner ✓ Death			R/Outpatient			4 ∐ Nu			$\overline{}$	Other (Sp	ecify)	HOSPICE
0 0	ding I h. After funer	ate	Natural 5 Pending	28a. Date of injury (Month, Day,	Year)	28b. Time of injury	M 28	Bc. Injury work?	at ′es 2□	- 1	8d. Describe h	now injuly	ry occurred		
Sio	Attendi r death ctor: A by the fi	Certificate:	Accident Investigation 3	28e. Place of Injury	y - At hon	ne, farm, stre			es 2 🗆	_	8f. Location (S	Street an	nd Number or i	Rural F	Poute Number
Division of Vital Records, P.O. Box 687	ital or A Just after ral Direct lled in by			building, etc.	(Specify)						City or Tow	n, State	a)		,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir 3 Certifying Nurs	ician: To the best of m ner: On the basis of exa e Practioner : To the b	amination	and/or investi	gation, in n	ny opinion	, death oc	curred at t	he time, date a	and place	e, and due to th	e caus	e(s) and manner stated.
	To the vithin comp		29b. Signature and title of certifier				29c.	License	number			29d. Da	ate signed (Mo		
									00-	580	410		5/4	100	,
			30. Name and address of person who co	ompleted cause of dea	ath (Item :	23a) (Type, Pr	rint)		~ ~	2 /	410 Haj	1.	1 1 1	_	2 12
	- 01-		31. Date filed (Month. Day Year)	32 Projetor	's Signati	0 /	130	190	13	5 5	day	isu	pg w	0	2/802
	Stat Registra	e er	31. Date filed (Month, Day, Year)	10 Agent	Joignath	9. Aga	N/Sa						ı		

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			For State Registrar		State o	of Ma	ryland		artmer <i>rtifica</i> :				fental Hy	/giene Reg. No.	010)	16887
			1. Decedent's Name	e (First, Middle,	Last)								2. Date of D			,	3. Time of Death
Н	Physici /Medio		GARRY	PAUL N	EAL								MAY 1	19, 20	010	re ar	6:27A M
	Examir		4a. Facility Name (/	f not institution,	give street and nu	ımber)			4b. City,	Town, or	Location	of Death		4c.	County of	Death	
- John State			27 BLA	CKPOOL	CIRCLE	C			1	VALD	ORF			CI	HARL	ES	
	Funeral Director		5. Social Security N 577-56-		3. Sex 1 ★ M 2 □ F	7. Age	(In yrs. la	st birthday Yrs.) If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B. (Month, D. 6 – 7 –	rth lay Year) 1944	9	9. Birthp Coun MD •	lace (State or Foreign ntry)
	p .		Usual Residence of														
	how		10a. State	10b. County	TRO		10c. City,	Town or L								11	0d. Inside City Limits
	a-f s	Director	MD.	CHAR	LES				WALDO)RF							1 ☐ Yes X☐ No
	or 28	ire	10e. Street and Nur						10f. Zi	Code				10g. Citi	zen of Wh	at Coun	itry?
	th with the Marylan 23a or 28a-f show	je.	27 BLA	CKPOOL	CIRCLE	C				20	602			U.S	S.A.		
036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		12. Was Dec Armed Fo 1 [Yes If Yes, Gi Year or D	orces? 2 XNo ive		. 13	Was Dece If Yes, spe 1 □Yes		ispanic Or In, Mexica Specify		ecify Yes or N Rican, etc.)		14. Race - Black, Specify:	White, 6	etc.
5-0	72 ho	etec	(Spec	15. Decedent's	Education grade completed)		Ţ	(Giv	edent's Usu	rk done c	turina mos	st of work	ina		nd of Busi		dustry PECIALIST
21215-0036	d within giene. or than	Completed	Elementary/Seco	ndary (0-12)	College (-)		JO NOT L			ERA	ror	INC		G 5.	PECIALIST
þ	be filed Ital Hyg d other event,	Be C	17. Father's Name	(First, Middle, L	ast)						18. Moth	er's Name	e (First, Middle	e, Maiden	Surname)	,	
<u>a</u>		To	JOHN	McVEY	•						JO	YCE	ELAIN	E BF	RITT	ING	HAM
Maryland	nd 2 should alth and Mer 27 is marke r traumatic		19a. Informant's Na		, , , ,				ing Address				al Route Num.	ber, City o			,
altimore,	Pages 1 ament of Heannt of Heannt: If item		20a. Method of Disp 1 ☐ Burial 2 ☐ 4 ☐ Donation	position XCremation 3 5 □Other (Spe	3 □ Removal from	State MET	20b. Pla ce	on of Disa	anitian /Ala	me of other plac	e)	Į	Date 23-10	20c. Lo	cation - C	ity or To	
Balt	permit, Departr Importa any Inju		21. Signature of Ed			947			2. Name a	nd Addres	ss of Facili	itv	SERVI				

Physician /Medical Examiner

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any section to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last aminer

IF FEMALE:

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. cances Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Approximate Interval Between Onset and Death

Year

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

29d. Date signed (Month, Day, Year)

Day

	h	ă
		v/Medical
		Physician
		Completed by
		To Be
		Certification:
	ŀ	7

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow					
		24a. Was an autopsy performed? 1 \(\subseteq \text{tes} = 2 \) \(\subseteq \text{No} \) 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\subseteq \text{tes} = 2 \) \(\subseteq \text{No} \)					
25. Was case referred to medical examiner?	26. Place of Death (Check only one)					
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 512 Residence 6 □Other (Specify)					
27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of linjury 28c. Injury at Work? 1 Yes 2 No	id. Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 Certifying Phy (Check only one)	rsiclan: To the best of my knowledge, death occurred at the time, date and place, ar iner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)					

29c. License number

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 8, 2010 Annabelle Marie Pulsinelli 11:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Calvert Prince Frederick The Burnett-Calvert Hospice House If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F PA Country) 10/26/1921 Director 261-22-8610 88 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No MD Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10600 McQueen Drive 20657 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: and Mental Hygiene.
is marked other than "natural", If Yes, Give Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Beautician Hairdressing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John W. Neverline Catherine Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Richard C. Pulsinelli (Son) 10600 McQueen Drive, Lusby, Maryland 20657 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Metropolitan Crematory 5/13/10 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600. Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Parkinsons Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy rmed? 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical director, æ 26. Place of Death (Check only one) Certificate: To 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at House 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 2 Accident
3 Suicide the f Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47610 May 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David J. Tardio, MD14090 Solomons Island Road, Solomons, Maryland 20688 31. Date filed (Month, Day, Yea 32. Registra s Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.0

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrarment #5 per FH 5/20/10 PCH FIM Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ Month Esther M. Puma 11:30 PM May 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Takoma Park Montgomery Sligo Creek Nursing Home 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Days Hours (Month, Day, Year) February 24 Months 89 Arequipa, Peru Director 1921 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Prince George's Hyattsville 1 🏻 Yes 2 🗆 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4703 41st Street 20781 USA items ? 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced Peruvian Specify: Hispanic Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Private 12 Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ဂ္ Nestor Huaco Carmen Medina permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay G. Puma / Son 4703 41st Street, Hyattsville, MD 20781 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State George Washington Cemetery 5/17/2010 Adelphi, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Liver Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or impury that initiated events Due to (or as a consequence of) Examil the Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 2 X No detached 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page performed? Yes 2 X No certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🛭 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27 Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D45471 5/13/2010 ompleted cause of death (Item 23a) (Type, Print) 1111 Spring Street, Suite #214, Silver Spring, MD 20910 Yeheyis Negussi/e, Date filed (Mo 32. Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 May 11, William Joel Pototsky 9:21 P. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Month, Day, Yes Days 1 X M 2 □ F Hours Min. 012-20-3976 Director 85 MA Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Montgomery 1 Tyes 2 X No Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4925 Battery Lane, 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No Black, White, etc. <u>8</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give 1943 Year or Dates. 1970 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Specify: Completed Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed within 72 h h and Mental Hygiene. 7 Is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Naval Aviator U.S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Murray Pototsky Ilonka Presser and 2 should the Health and Metern 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Pototsky, Son P.O. Box A, St. Mary's City, MD 20686 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 \square Burial 2 $\overset{f X}{f X}$ Cremation 3 \square Removal from State Atlantic Crematory 05/15/2010 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thibadeau Mortuary Service, p.a. 7 Park Avenue, Gaithersburg, MD 20877 Prin m? M01508 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Medical resulting in death) Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence or). ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown detached 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by otots Ky, William D. Division of Vital Records, LARYNGEAL CARCINOMA, CHRONIC OBSTRUCTIVE PULMONARY 1 Yes 2 No 3 Probably 4 Unknown DISEASE, TYPE II DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Hospital or Attending Physician; The 1 ☐ Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 Tes 1 Inpatient 2 I ER/Outpatient 3 🔀 DOA မ this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🛚 Natural (Month, Day, Year) 5 Pending injury 1 Yes 2 No Accident Investigation the 6 Could not be To the Hospital or Atterview within 24 hours after de To the Funeral Directo completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3+1 H45839 MAY 12, 2010 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY E. RAFFEL, DOFACP, 11119 ROCKVILLE PIKE, SUITE 316, ROCKVILLE, MD 20852 31. Date filed (Month, Day, Year) MAY 14 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pozdnyakov Physician/ Anatoliy 2010 9, 0115 May M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death .. County of Death Montgomery Examiner Rockville Casey House Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Days Hours 81 216-63-9803 1^{(M}2^O7^{(th}1 ^D7^{y,}/ 9928 ^{Country)} Russia Director Usual Residence of Deceden item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Gaithersburg Montgomery 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 5 Narrowleaf Court 20878 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc 1 Never Married 2 Married ò Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Government Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fyodor Sergyeevich Pozdnyakov Marina Timofyeevna Pozdnyakaya should be 19a. Informant's Name/Relationship (Type, Print) Olena A. Robertson/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Narrowleaf Court Gaithersburg, Md
20878 permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other traa once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Bemoval from State ROCK Creek Cem. Washington, D.C. 5/12/2010 4 Donation 5 Other (Special PHTTPPADERTNALDI FUNERAL SERVICE, P.A. Signature 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Melanoma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or in jury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy ☐ Yes 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospita 1 ☐ Yes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) hospice 욘 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29b. Siama 29c. License number 29d. Date signed (Month, Day, Year) May 9,2010 11510 (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death 6001 Muncaster Mill Road Rockville, Md 20855 CRNP Diane Ruckert 31. Date filed (Month, Day, Year) 2. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 24a per phys. G904 6/11/2010 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Jean H. Potter May 13, $12:30 p^{M}$ 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EDENWALD RETIREMENT COMMUNITY TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖺 F Months 218-20-7054 83 Director Yrs 05/16/1926 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel", or items 23a or 28e-f shov Examiner must be notified at Director 1ĂYes 2 ☐ No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Lochview Court 21093 USA death \ Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Pages 1 and 2 should be filed within 72 hours after of trent of Health and Mental Hygiene. Inter of Health and Mental Hygiene. Int: if item 27 is marked other than "naturel", or ite 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 K No Specify: 3 X Widowed 4 Divorced white event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) teacher education Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Thomas Holland Jr. Jane Kirwin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Lochview Court, Timonium, MD 21.093 Michael Potter/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
WICOMICO MEMORIAL
PARK 20a. Method of Disposition Date 20c. Location - City or Town, State injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State important: if eny injury or 4 □ Opnation 5 □ Other (Specify) 5/17/2010 Salisbury, MD 21. Si majure of Funeral Service-Lio-fise Holioway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 on the 3a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** stage vascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed as the burial-tran the attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No o 9 Unknown 9 Unknown been signed by ۵, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ The law requires Completed 1 🗌 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy 2 X No 1 ☐ Yes 2 ☐ No 1 □ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

32 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R154032 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susar Scherr CRNP 800 Southerly Rol Towson, MD 31. Date filed (Month, Day, Year) Legistrar's Signature State Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23a,28a,c,d per me g904,06/09/2010dhb

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month D. Parks Wayne 2010 May 7:36 p Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Montgomery Suburban Hospital Bethesda 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. (Month, Day, Year)
ept. 10,1953 Washington, D.C Director 225-78-4614 56 Sept. Usual Residence of Decedent show 10b. County : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director VA Fairfax Great Falls 1 X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 1007 Kimberly Place 22066 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 X No 21215-0036 African permit. Page 1 and 2 should be filed within 72 hours aff Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Evan If Yes, Give 1 ☐ Yes 2 💢 No Specify: 3 Divorced 4 Divorced Year or Dates American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Psychologist Own Business Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Warren Parks Flossie Spivy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita S. Parks/Wife 1007 Kimberly Place, Great Falls, VA 22066 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory | 05/25/2010 | Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part Center the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ disease or condition resulting in death) Suicell - ovedose **Medical** Due to (or as a consequence of) Examine Sequentially list conditions. Due to wr as a cons quence of: Examine if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit executed CERTIFICATION APPROVED BY MEDICAL EXAMINER that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director: After this certificate has been signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No 25. Was case referred to medical examinar?
1 ✓ Yes 2 ☐ No of Vital Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Found 1930 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28d. Describe how injury occurred **Subject ingested drugs.** 28c. Injury at 1 Natural 5 Pending Division 1 X Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation May 19,2010 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 404 UNIVERSITY within 24 hours a

To the Funeral D

completed filled Bluck, MCb Mayland Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number ٥ 29d, Date signed (Month, Day, Year) CM 66895 May 19,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Bellaudy MA Samiento SUSULSAN 8000 and beargetown Rel. Hos otta

State

Registrar

31. Date filed (Month, Day, Year)

25 2010

0116

WAYNE

PARKS

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year Doris Sheets Rue 0424 M 05 Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth (Month, Day, Aug. 8, 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😾 F Days Min. 216-14-2627 85 Director Yrs. 1924 Maryland Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 1 ☐ Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 1679 Town Point Road 21613 USA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married 21215-0036 hours after 1 ☐ Yes 2 🛣No Specify: white 1 and 2 should be filed within 72 mouses.
of Health and Mental Hygiene.
If item 27 is marked other than "natural" Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ray Walsh Sheets Mary Elizabeth Robbins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 323, Cambridge, MD Wendy Rue daughter in law permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Old Trinity Churchyard 5/20/10 Church Creek, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and-trar Due to (or as a consequence of) burialby the attending physician tached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 \(\subseteq \) Yes 2 \(\subseteq \) No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Accessive within 24 hours after death.

To the Funeral Director; After this certificate has the Funeral director, page 2.8 autopsy performe 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate; 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation 1 🗆 Yes 2 🗆 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s Certifying Nurse Practioner/ To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) H54827 30. Name and address of person who completed ca 23a) (Type, Print) use of death (Ite 1008. CARNOU St. SALISBURY Md. 21801 6ittElma d (Month, Day, Year)
MAY 18 2010 32. Registrar's Sig State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 [] | State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate of Death						Reg. No.							
Physici										Date of Death 3. Time of Death						
ledical Exami	iner	Daniel Robinson Jr.							1	Month Day Year May 7, 2010				1034 hr	'S	
		4a. Facility Name (if not institutio		umber)		4t	o. City, Town, or	r Location o		, ,		c. County o	f Death			
		Anne Arundel Medical	l Center				Annapolis				- 7	Anne Aru	undel			
Funeral		Social Security Number	6. Sex	7. Age (In	yrs. last birt	hdav)	If Under 1 Yea	ar If Unde	er 24Hrs.	8. Date of Bir	rth/MN	WDD/YYYY	9. Birt	hplace (State	or	
Director		247-11-0439					Months Day		Min				Foreig	n		
			1 M 2 F		4	7 _{Yrs.}			7	Sept 3	30	1962	2 Sount@arolina			
.		Usual Residence of Decedent		1100	Oit Tour	- Locatio								10 d tasida 6		
wany		10a. State 10b. County			City, Town									10d. Inside C	•	
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faryl:	Director	10e. Street and Number					10f. Zip Code				10g. Citizen of What Coun					
the N	늅	3678 Thomas Point Rd.					214									
with 18 23 8 8 10 0		11. Marital Status						as Decedent of Hispanic Origin? (Specify Yes or				USA	can Indian, Bl	lack		
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with with her t	E C	12th	lyr			Ca	regive		Mother's Name (First, Middle, Maiden Su				nn Care			
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hould Mark is my		19a. Informant's Name/Relations					Address (Stree									
S & F		Cynthia E. Wi	lliams(1403	
Fiter Hear		20a. Method of Disposition	- D-movel f	2	20b Place o	Disposition	on (Name of cer place)	metery,	D	Date	20c.	Location -	City or	Town, State		
Baltimore, permit. Pages 1 ar Department of Hee Important: If itel injury or other tr		M.					Garde		5-15	15-10 Annapol				lis, Md.		
ortar		4 Donation 5 Other Sc 21. Signature of Funeral Service	noi opecity.								ctuary, P.A.				•	
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traur				6 ag			1 West									
_	\dashv	23a. Part I. Enter the disease, or	complications that of		loath Dong					_				401 Approximat	- Internal	
Physician /Medical		failure. List only one cause	on each line.	auseu uro u	eaut. Do	A enter and	mode or dying,	Suu i as w	dialac or 10	aspiratory a	85t, 311	OCK, OF TREAT	n.	Between O	Inset and	
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		or condition resulting in death)	Due to (or as a	a consequen	ice of):											
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	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	a consequen	ice of):									1		
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x 68760, th certificate but tending physic ruse as the bur	M	IF FEMALE: 23b. Was decedent pregnant in th		outcome of painth		□ Sets		Ectopic	anana		23	3d. Date of d	•		V	
certil	iar	past 12 months?	I _ LIVE I	οιττη nant at time o				Ecropic	pregnancy	у		Month	U	ay	Year	
Box 68 ne death certif	Physicia	1 Yes 2 No 9 Unk	known 9 Unkn		5	Utne	er (Specify)									
the d	됩	Part II. Other significant conditi			not resulting	a in the una	deriving cause g	niven in Par	rt I.	23e. Did to	bacco	use contrit	oute to t	he cause of d	leath?	
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tal R cian: T certifica ector, pa																
Vita ysicia his cer direct	a	examiner?	Hospital: 1	Inpatient 2	ER/O	utnatient		Other	Nursing H		Resid	ence 6	Other:			
of Vi ing Physi After this uneral dir	은	1 ✓ Yes 2 No 27. Manner of Death		of Injury		Time of Inju		ry at Work?								
C = . ~ = !										o water						
SiO Vitten deat ctor	ati	2 Accident Investigation Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)														
Division tal or Attendi rs after death. al Director: A	ij										nber, City					
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ခြွ	4 Homicide determined (Specify) Bay 2 Naval Academy Bridge, Annapolis, MD														
Hos 24 h Fur etcly																
To the within To the comple	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)														
Faro	Σ	29b. Signature and little of pertifies 29c. License number 29d. Date signed (Month, Day, Year)														
	0.C.M.E. May 8, 2010															
		30. Name and address of person who completed cause of death (Item 23a)														
JIT ?		Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201														
#		31. Date filed (Month, Day, Year)		∉ gistrar's Sig					-, 1112 21							
Regist		MAY 12	2010	, gistial s oig	Jilatare A	hour										

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 05709/2010 LELIA REBECCA REESE 10:25 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cherry Lane Nursing Center Prince George's Laurel . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/01/1935 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Days Director 219-48-7462 75 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 ☐ No MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a 20707 USA 620 8th Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Hygiene. other than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Completed 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Worker Agricultural Library and Mental Hygie is marked other Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard S. Jackson Ruth M. Wesley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Reese - daughter 620 8th Street, Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from St MD Nata Mem. Park 5/17/10 4 Donation 5 Other (Specify) Laurel, MD Signature of Funeral Service License 22. Name and Address of Facility Snowden Funeral Home Washington St, Rockville, MD 20850 N. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between shock, or heart failure. List Onset and Death Immediate Cause (Final Physician/ ά disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence Exami attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year s been signed by the should be detached Part II. Other significant conditions contributing to death but not respecting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an cate has b autopsy performed? Yes 2 N prior to completion of cause of death?

1 Yes 2 No this certificate **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Acciden 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my spiritude death occurred. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) .

SYEX SAND 14333 LAUGE DOWLE 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

14 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician**)MeC 010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** 1 X M 2 🗆 F Yrs 09/10/1949 216-02-5742 Afghanistan 60 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location show 1 Tyes 2 X No Director must be notified Columbia 28a-f Maruland Howard 10g. Citizen of What Country? 10f, Zip-Code 10e. Street and Number ö U.S.A. items 23a 9008 Nelson Way 21045 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates: 2 X No 21215-0036 1 Yes 2 X No Specify. ö ð White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Accounting Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Maryland Be and Mental I Pages 1 and 2 should be Zobayda Popal Ahmed Mir Royan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11684 Cedarline Court, Ellicott City, MD 21042 of Health Mena Jalali - Daughter other Baltimore, item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State = 5 Important: If any injury or once. Comfort Cemetery 05/14/2010 Alexandria, Virginia Mt. 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between Onset and Death inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Pa 1. Enter third, ease, in complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) 40 CANDI Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, Examine nding physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No Yes 9 Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 2 No 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After this 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: Injury 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, 3 Suicide 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29d. Date signed (Month, Day, Year) 290 License number 29b. Signature 1100

State Registrar SIL MCEVOY

31. Date filed (Month, Day, Year)

MAY 14 2010

32. Registrar's Signature

ess of person who completed clause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra 3. Time of Death 2:57 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thelma ам Anna Russell 2010 May 12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days Hours Min. June 22, Year 1936 197-28-3011 73 Pennsylvania Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 □ No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20912 7402 Carroll Avenue USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 **x x**No Maryland 21215-0036 1 ☐ Yes 2 x No Specify: White Specify: "natural" 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nt of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Medical Secretary Hospital Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph B. Breeze Anna Buran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley Marvin Russell/Husband 7402 Carroll Avenue, Takoma Park, MD 20912 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Webber Brook Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date া Burial 2 🗆 Cremation 3 🛮 Removal from State [18, Oxford, Maine 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee

22. Name and Address of Eacility
Francis J. Collins Funeral
500 University Blvd. W., Si

33. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock or heart failure. List only one cause of each line. 22 Name and Address of Each Trancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Immediate Cause (Final rogrevive Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, Exami executed and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Tyes 2 🗌 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signate and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20/0 30. Name and address of person who completed of James K. Lightfoot, M use of death (Item 23a) (Type, Print) 7600 Carroll Avenue, Takoma Park, MD 20912

State

MD

32. Registrar's Signature

31. Date filed (Month, Day, Year) **MAY 14 2010**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** 10:00 ДM PATRICIA ANN RIFFLE May 10, 2010 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20014 Rosebank Way Apt. 112 Hagerstown Washington If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Reb. 5, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Maryland Director 577-46-8092 77 Usual Residence of Decedent with the Maryland 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examin or must to redified at 10a, State 10b. County 10c. City, Town or Location 1 √Yes 2 □ No Director Maryland Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20014 Rosebank Way Apt. #112 21742 U.S.A. Funeral death permit. Pages 1 and 2 should be filed within 72 hours after dea; Department of Health and Mental Hygiene. Important: If fiem 27 is marked other there? any Injury or other traumation. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐ Yes 2 X No <u>۾</u> Specify: 3 Widowed 4 N Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Housekeeper Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Glenn Renner Ann Elizabeth Stitely ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Bennett Court, Thurmont, Maryland 21788 Kevin R. Riffle / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 5/14/2010 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) re o Funeral Se ROBERT Eddre Daffeey & son funeral homes, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MYDVICE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed burial-transi Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Year 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 🔲 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The performed? Yes 2 No 1 □Yes 1 ☐ Yes 2 □No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 2 1 No After this ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. I Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours after To the Funeral Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and makiner states. 29b. Signature d title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person cause of death (Item 23a) (Type, Print) 4 Kei Pi N. Walnu 31. Date filed (Month 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month PAUL KENNETH RICHARDS May 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbut aston Memorial Hospitai If Under 1 Year | If Under 24 Hrs Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 **X** M 2 □ F Hours Maryland 218-24-2572 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Caroline Preston MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7489 Harmony Road 21655 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 Married 2 No X XYes 1 ☐ Yes 2 🗓 No Specify: White 48-52 3 - Widowed 4 - Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 9 t h College (1-4 or 5+) Truck Driver permit. Page 1 and 2 should be filed with.
Department of Health and Mental Health and Mental Health and minjury or other. Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Elbert Richards Ethel Lillian Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy L. Richards/Wife 7489 Harmony Rd. Preston, MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 5/14/2010| Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <u>Veterans Cem</u> 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Framptom Funeral Home, Federalsburg, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Filysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
g Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the a 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas certificate 1 Yes 2 No Yes Be Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No မ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending injury 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 24 hours a Funeral I Medical 29a. Certifier 1-🗐 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number

St

Paul

Richards

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signati

10-03521 Betsy Riggin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2

		1- For State Registrar	-		Certific	ate of	Death		,	Re	eg. No.		
Physicia									2	Date of Death Month Day Yea			3. Time of Death
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								r Location	of Death		4c. County o		
		3221 The Alameda		Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.				Baltime Baltime B. Date of Birth(MM/DD/YYYY) 9. B					
Funeral Director		5. Social Security Number 325-72-2204	6. Sex			inday)	If Under 1 Year Months Day		_	8. Date of Bin	th(MM/DD/YYYY)	Foreign	n
Director			1 M 2 F		29	Yrs.				07/30	/1980	Cou	^{intry)} Illinois
any		Usual Residence of Decedent 10a, State 10b, County		110	c. City, Town	or Locatio	n						10d, Inside City Limits
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d be i fental	Be	Weldon Joseph 19a. Informant's Name/Relationsh	Riggin		140	. Mailing	Adda (0)		hy Du		ber, City or Town	01.1	7: 0.1)
shoul and N 7 is m	٩			. 1							200		Zip Code)
and 2 and 2 fealth tem 2 traus		Weldon Joseph 20a. Method of Disposition	Kiggin/i	athe	20b. Place of	of Dispositi	on (Name of ce	netery,	Road	<u>. Eden</u> Date	MD 218 20c. Location -	22 City or 1	Fown, State
IOF it of I	MD Baltimore Baltimore 10e. Street and Number 10f. Zip 10e. Street and Number 10e. Street and Number 3221 The Alameda 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent 14. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent 14. Marital Status 14. Marital Status 14. Marital Status 14. Marital Status 14. Marital Status 14. Marital Status 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual during most of work 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual during most of work 17. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Mailing Address 18. Mailing Address 19. Mailing Address								05/11	1/2010	Salichu	***	Maryland
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Physician		23a. Part I. Enter the disease, or o				t enter the	mode of dying,	such as c	ardiac or re	espiratory arre	cess Ann est, shock, or hea	rt r	Approximate Interval
/Medical		failure. List only one cause of Immediate Cause (Final disease	a. Asphyxia b	y stranc	ulation								Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a										
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		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, o			Fetal	death 3	Ectopic	c pregnanc	v	23d. Date of o	delivery Da	ay Year
Sox 687 leath certifi.	icia	past 12 months?	4 🗸 Pregn		of death 5		(Specify)		- p g	,			-,
Box e death c the atten	Physician	1 Yes 2 No 9 Unkr	own 9 Unkno	wn									
Records, P.O. Box 68 The law requires that the death certif are has been signed by the attending age 2 should be detached for use as	면 교	Part II. Other significant condition	ons contributing to	death bu	t not resulting	in the und	derlying cause of	given in Pa	art I.				he cause of death?
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cords, law requir has been s	plet									24a. Was a autops	y pr	ior to co	opsy findings available empletion of cause of
Rec The la	Completed									perform 1 Yes 2		eath? ✔ Yes	2 No
	a	25. Was case referred to medical examiner?	Negrital:				26. Place	of Death ((Check onl	y one)			
ion of Vital tending Physician: leath. tor: After this certif the funeral director.	리	1 ✓ Yes 2 No		npatient		tpatient			Nursing I		Residence 6		Scene
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Division pital or Attendion ours after death.	Certification:	determ	not be			rm, street,	factory, office b	bullaing, etc		or Town, St			al Route Number, City
Lospit 4 hour uners		29a. Certifier	(0,750)/			th occurre	d at the time, do	ate and pla			· · · · · ·		d .
Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
5 H & H	B	29b. Signature and title of certifier	and manner st	aled.	1		29c. Licens	e number			29d. Date signe	d (Mont	th, Day, Year)
XTJ		O.C.M.E. May 7, 2010											
5	ŀ	30. Name and address of person v	vho completed caus	e of geath	(Item 23a)								
~		Zabiullah Ali, M.D. A	ssistant Medic	al Exan	niner 11	1 Penn	Street, Balt	imore, N	MD 2120)1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day JAY CALVIN REED, JR. РМ 05 2010 Medical 3:56 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10306 DEAN DRIVE NW ALLEGANY LAVALE Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth Days Hours Min 1 M 2 - F 0972271938 Yrs. Director 204-28-1135 71 PENNSÝL VANTA Usual Residence of Decedent 28a-f shov 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD ALLEGANY LAVALE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 10306 DEAN DRIVE NW 21502 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 😿 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: WHITE 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other tranmation. Elementary/Seconday (0-12) College (1-4 or 5+) PRODUCE MANAGER RETAIL GROCERY STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JAY CALVIN REED, SR. ADA PAULINE GRUBB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>10306 DEAN DRIVE NW, LAVALE, </u> MD 21502 MARY M. REED / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 05/19/2010 REST HAVEN CEMETERY LOCK HAVEN, PA Signature of Funeral Service Licenses HAFER FUNERAL SERVICE, P.A. 1302 NATIONAL HWY., LAVALE, MD 23a. Part 1 Enter the disea e or complications had cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Wit only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a ENDSTAGE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? \$ Records, 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No 1 🗌 Yes 2 🗷 No of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, funeral 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete Suite 302 Cumberland, MD 200 GlennSt. <u>Robustiano J. Barrera</u>

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State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

State Registrar

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AVE LAPLATA MD 20646

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M)

Michael Doff

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 590 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mildred Byrne Stevenson May 13, 2010 8:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Lusby 265 Deer Drive Calvert If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖼 F Months Days Hours March 14. Director 578-16-1193 91 1919 Maryland Usual Residence of Decedent 28a-f show 10b. County the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 H No Marvland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 265 Deer Drive 20657 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 H No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant, If item 27 is marked other than 'ury or other traumatic event, <u>the Me</u> Elementary/Seconday (0-12) College (1-4 or 5+) Housewife <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Clifton Byrne Erma Cecil Kanode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Stevenson / Daughter 265 Deer Drive, Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 05/14/2010 Alexandria, Virginia 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. 22. Name and Address of Facility P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLEROTIC CARROVASCULAR DISEASE Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on Examir and -tran Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ Pregnant at time of death Month Day Year 2 No ed by the a detached t 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PARKINSON'S DISEASE 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မြ 1 Tes 2 **N**No 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending iours after death.

neral Director; Aff
filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Hospital Medical 29a Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D31563 May 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Benner, MD 20945 Great Mills Road, Lexington Park, Maryland 20653 31. Date filed (Month, Day, Year, 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Skinner 1: 36 AM May 2010 Judy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 M 2 X F 07-12-1949 579-66-0677 60 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a4 show 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 1 ¥ Yes 2 ☐ No **Funeral Director** must be notified MD Calvert North Beach 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 9640 Seashell Court, Apartment 103 20714 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 📆 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Communications Officer Calvert County Govt. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jackson Clarence Weaver Helen Elizabeth Hetterly ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trauonce. Dennis C. Skinner, spouse 9640 Seashell Ct., Apt. 103, North Beach, MD 20714 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) So. Memorial Gardens 05-19-2010 Dunkirk, MD 21. Signature of Superal Service Licensee 22. Name and Address of Facility Rausch Funeral Home. P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 50 PS15 **Physician** disease or condition resulting in death) /Medical Due o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physician an Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 menths?
1 ☐ Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 Accident 1 Director: A 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a

To the Funeral C

completely filled 29a, Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Signature and litle of certifier, 29d. Date signed (Month, Day, Year) 29b. 29c. License number RES 000 May 14 2010

State

Registrar

PAYAM

31. Date filed (Month, Day, Year) 32. Registrar Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHASSEL

A. pares

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Naomi Hope Sprecher May 7:31 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery The Casey House Rockville Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕅 F Davs Hours New York March, Day Director 059-20-7336 85 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at. 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Alexandria Virginia|Alexandria City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22305 70 Kennedy Street United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural" 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Synagogue Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Moe Garfinkel Ida Copans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14226 Greenspan Lane Rockville, Maryland 20853 Richard Sprecher / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot X Burial 2 Cremation 3 Removal from State May 17, 4 ☐ Donation 5 ☐ Other (Specify) Agudus Achim Cemetery Alexandria, Virginia 21. Signature of Funeral S Service Licensee 22. Name and Address of Facility 5755 Castlewellan Drive Barnhari Jefferson Funeral Chapel Alexandria, Virginia 22315 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Infarct involving the right Parietal, Temporal and Occipital lob Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) Yes 2 X No 1 Yes 2 9 Unknown 9 Unknown the ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 No Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) Hospice House After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No X Natural iniury 5 Pending 2 Accident Investigation s after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 6001 Muncaster Mill Rd.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

M.D.

Bindu Joseph,

D60634

May 14, 2010

Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth H. Schneider P^{M} 201 2:44 May 6, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Mandrin House Harwood 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Date or Day, Ye Funeral 1 □ M 2 🛣 F Months Days Hours Min. Year) Director 216-58-5720 92 Maryland Sept Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City. Town or Location Director 1 Yes 2 No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20720 USA 5703 Church Rd. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 \square Never Married 2 \square Married Ş 3altimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the lone. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Stephen Clifford Lanham Helen Brady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Schneider / son 120 Weymouth St., Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 5/10/ 2010 Brentwood, MD 22. Name and Address of Facility Beall Funeral Home Funeral Service Licensee 6512 NW Crain Hwy., Bowie, ock, or heart failure. List only one cons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Immediate Cause (Final set in Deal lenkama Physician/ myelminou disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Vear ☐ Pregnant at time of death☐ Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn Yes MANDRIA 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: HOUSE 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Accident Investigation ☐ Accider ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Sigr atu 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

1 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29c per DVR G904 6/2/10 dk.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 ear Dora Schultz May 8:50 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1801 E. Jefferson Street, Rockville Montaomeru Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) New York 1 □ M 2 💢 F Months Days Hours Min. Director 101-09-2429 93 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1801 E. Jefferson Street, 20852 U.S.A. hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: 3 X Widowed 4 Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Public Education other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or com-Philip Gildward Sarah Feinstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen N. Zwibak - Daughter 3001 Veazey Terrace, NW. #327, Washington, DC20008 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗓 Removal from State 05/10/2010 Pinelawn. New York 4 Donation 5 Other (%pecify) Beth Moses Cemetery gnature of Fun S rvio Lice ee 22. Name and Address of Facility Hines-Rindldi Funeral Home, M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Malignant Neoplasm of Uterus Securities if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) physician and the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records. P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Year Pregnant at time of death Day 1 ☐ Yes 2 № 9 ☐ Unknown Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed? Yes 2 No 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မ 1 Yes 4 Nursing Home 5 X Residence 6 Other (Specify 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title

Registrar

of certifie

Susan J. Miller,

8218 Wisconsin Avenue, #305

Jun-

Registrar's Signat Seule

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

29c. License number

D35579

29d. Date signed (Month, Day, Year)

May 9, 2010

Bethesda, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per phys. 6904 6711/10 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Charles 9:30 PMM R. Spiker 2010 May 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Somerset Gardens Princess Anne Somerset 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F 224-03-6515 Director 94 04-18-1916 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 K Yes 2 □ No Shenandoah VA Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2167 Moore Road 22664 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 No Yes 2 No No No No No Year or Dates: WWII Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi f Health and Mental Hygien item 27 Is marked other th none Carpenter Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles S. Spiker ပ Mary Elizabeth Hottel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Pantos/Daughter 709 Laurel Ave., Ocean City, ce of Disposition (Name of Date Baltimore, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset View Cemetery 02/12/2010 Woodstock, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral 22. Name and Address of Facility Hinman Funeral Home M00295 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Immediate Cause (Final disease or condition resulting in death) **Physician** BMBNTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-tran Due to (or as a consequence of): 68760 physician Physician/Medical the Physician: The law requires that the death certificate attending p Box IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 0 the 9□Unknowr 9 Unknown þ ٦ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 sl 24a. Was an autopsy performed' 8€ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 2 1 ☐ Yes this Other (Specify) ASSISSTED LIM 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospital or Attending Natural 5 Pending investigation n 24 hours after death.

ne Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No ∠ □ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

State Registrar 31. Date filed (Month, Day, Year) 32.

Hausm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PO

32. Registrar's Signature

30 p

2180

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CLARENCE EDWARD SMITH 5/20/2010 3:25 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 25711 GAREY RD. DENTON CAROLINE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 € M 2 □ F Months Days Hours Min. Director 217-38-7334 70 4/16/1940 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any lijury or other traumatic event, IT is The Acrel Examiner must be mattered once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MARYLAND CAROLINE DENTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25711 GAREY RD. 21629 Funeral USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1

Yes 2

No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) POLICE OFFICER LAW ENFORCEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY WATSON TAYLOR SMITH P LILLIE VIRGINIA O'NEILL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIE CATHERINE COMPTON SMITH / WIFE 25711 GAREY RD., DENTON, MD 21629 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State 5/21/2010 4 ☐ Donation 5 ☐ Other (Specify) MID SHORE CREMATION CENTER CAMBRIDGE, MD 22. Name and Address of Facility MID SHORE CREMATION CENTER, 2272 HUDSON RD., CAMBRIDGE, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 years disease or condition resulting in death) Maligna /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the human transmit. that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 (XNO 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 TYes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 □ Other (Specify) 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 232 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Idlew: Dr. Mary S. DeShields ner 21601 Ca 31. Date filed (Month, Day, Year) egistrar's Signatu 32 State

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Registrar

JUN 01

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George Ε. Turnbull, Sr. May 11, 2010 11:47 a^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 🛛 M 2 🗆 F Months Days Hours Nov. 29 Year 1921 172-14-8880 Pennsylvania 88 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at. Director 1 Yes 2 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2706 Higbee Road 20783 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11 Marital Status Armed Forces? 1 ☑ Yes 2 ☐ No Black, White, etc. δ 1 Never Married 2 MMarried Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Year or Dates. WWII 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education. 16b. Kind of Business Industry (Specify only highest grade completed) Id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental Fis marked or ပ George Frederick Turnbull Florence Lottie Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Patricia S. Turnbull/Wife 2706 Highee Road, Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) June 1, 2010 1X Burial 2 Cremation 3 Removal from State Arlington National Arlington, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility Ins. Funeral
500 University Blvd. W., Sil
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Name and Address of Collins Funeral Home Inc. O University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Wa hemey Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 certificate 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence 6 \(\triangle \text{ Other (Specify)} \) Hospital: 1 🗌 Yes 2 🔀 No ျပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 24 hours after death. Funeral Director: After 1 K Natural 5 \square Pending Investigation 1 Tes 2 No Accident npleted filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated vithin 2

To the F

complet To the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 8+1 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Padma Chirumamilla, MD 7600 Carroll Avenue, Takoma Park, MD 20912

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2010

. Registrar's Signature

10-03528		Please Type or Print in I	Black In	delible In	k. Ensu	re All Cop	ies Are Le	gible.	0 10010			
Charles Thompse		III State of Marylan				nd Mental I	Hygiene	201	0 0510			
		Registrar 1. Decedent's Name (First, Middle,Last)	Cei	rtificate of	Deam		2. Date of Dea	Reg. No.	3. Time of Death			
Physicia Medical Examir		Charles R. Thompson III	[Month May 7, 20	Day Year	0103 hrs			
Veg 2		4a. Facility Name (if not institution, give street and numb		4	b. City, Town,	or Location of Dea		4c. County of De	ath			
		University Hospital			Baltimore							
Funeral			Age (In yrs. I	ast birthday)	If Under 1 You Months Da			rth(MM/DD/YYYY) 9. I 1, 1963 For	eian			
Director		217-80-1686 1 M 2 F	46	Yrs.	Moritals	ays Hours III	Julie 1	1, 1905	CountryWirginia			
'n		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Location	on				10d. Inside City Limits			
iow any			ashington			own			1 Yes 2 X No			
uylanc ia-f sh	Director	10e. Street and Number		<u>-</u>	10f. Zip Code			10g. Citizen of What Co	ountry?			
he Ma 1 or 28		18322 Lyles Drive				21740	j	United States				
with t as 23a		11. Marital Status 12. Was Decede				lispanic Origin? (erican Indian, Black,			
death or iten	Funeral	1 Never Married 2 Married Armed Force 1 Yes	es? 2 X No			an, Mexican, Puer	White, etc.	31ack				
after	βy	3 Widowed 4 X Divorced If Yes, Give Year or Dates:			Yes 2 X N			Specity.				
hours fnatu		15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12) College (1-4)				oation (Give kind o fe. DO NOT use re		16b. Kind of Busines	s/industry			
36 hin 72 e. than '	ple	12	0, 5.,	Fore	man			Cons	truction			
5-0036 led within 7 Hygiene. l other than	Completed	17. Father's Name (First, Middle, Last)						Maiden Surname)				
21215 ould be file Mental H marked o	Be	Charles R. Thompson, Jr					oria Poli					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	은	19a. Informant's Name/Relationship (Type, Print)		19b, Mailing	Address (Str	eet and Number o	Rural Route Nu	mber, City or Town, Sta , Frederic	k MD 21702			
, MD nd 2 sho alth and em 27 is		Ashley Dotson / Daughter 20a. Method of Disposition	120h	Place of Disposit			Date	20c. Location - City				
Baltimore, pernit. Pages I an Department of Hea Important: If iter		1 Burial 2 Cremation 3 Removal from	State	crematory or other	er place)		/14/2010		ck, Maryland			
timent rrant:		4 Donation 5 Other Specify: 21. Signeture of Funeral Service Licensee	Kes		ame and Addre			l				
Bal Permi Depar Impo injur		21. Signature of Pulleral Service Licensee	/	22. 142				r Funeral Frederick				
Physician	Н	23a. Part I. Enter the disease, or complications that care	ed the death	. Do not enter the	e mode of dyin	g, such as cardiac	or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and			
Micical	1	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Be Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of):										
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executed an and al - transit	<u>a</u>	UNPENDED AMENDED										
60, ate be hysicii e burie	Physician/Medic	IF FEMALE: 23c. If yes, out	come of preg	nancy				23d. Date of deliv	ery			
68760, certificate be nding physici se as the buri	an/I	23b. Was decedent pregnant in the past 12 months?			aldeath 3	Ectopic preg	nancy	Month	Day Year			
Box (e death or the attended for us	sici	1 Yes 2 No 9 Unknown 9 Unknown	at time of de	eath 5 Oth	er (Specify)			1				
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be excertificate has been signed by the attending physician ector, page 2 should be detached for use as the burial	Ph	Part II. Other significant conditions contributing to de		esulting in the ur	derlying cause	e given in Part I.	23e. Did t	obacco use contribute	to the cause of death?			
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eco ne law te has	mp						perfo	ormed? death	?			
I R		25. Was case referred to medical			26.Pla	ce of Death (Chec						
Vita hysicis this ce	o Be	examiner? 1 • Yes 2 No Hospital: 1 • Inpa	atient 2	ER/Outpatient	3 DOA	Other Nurs	sing Home 5	Residence 6 Ott	ner:			
n of value of ding Ph	n: T	27. Manner of Death 1 Natural 5 Pending May 6, 201		28b. Time of In		ijury at Work?		how injury occurred motorcycle invo	lved in collision with			
ivision or Attendi after death. Director:	atio	2 ✓ Accident Investigation				Yes 2 ✔ No	automobile					
Division spital or Attendii hours after death.	Certification:	3 Suicide Could not be		ome, farm, street	, factory, office	e building, etc.	or Town,		Rural Route Number, City			
Hospital 24 hours & Funeral		4 Homicide 29a. Certifier 4 Certifying Physician. To the heat of		d / Highway	ad at the time	data and place, a						
9 H 4 9 P	Medical	(Check only one) 2 Medical Examiner: On the basis of e	xamination a	-								
To To com	Mec	29b. Signature and title of certifier	ed.		29c. Lice	nse number		29d. Date signed (f	Month, Day, Year)			
		0			0.0	C.M.E.		May 7, 2010				
		30. Name and address of person who completed cause of										
5		Donna M. Vincenti, MD Assistant Me				et, Baltimore,	MD 21201					
St Regist	ate trar		strar's Signati	A. Aca	de							
	-			-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:15P [™] Paul Francis Upaul 2010 Mav /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Denton Caroline Home for Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. Director 78 November 2, 1931 Pennsylvania 213-30-0671 Usual Residence of Decedent rat", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Caroline Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 21655 7835 Shore Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Ye ar or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: Caucasian 3 ☐ Widowed 4 ☐ Divorced "natural". Completed is 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the prediction 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement <u>1</u>2 Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Pau1 Upaul ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7835 Shore Drive, Preston, Maryland Wife <u>Margaret Ann Upaul</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Iter
any injury or oth 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/14/2010 Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 22. Name and Address of Facility Moore Funeral Home, P.A. 21. Sonature Funeral Service Licen 1000 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Lo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2 □No Ö the 9 Unknown 9 Unknown signed by the ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 - No Hospital or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 1 Yes 2 ₩o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specific Ospice ۵ After thi funeral o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 143 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, ¡Day, Year)

State Registrar Wafik Zaki,

31. Date filed (Month, Day, Year)

32. Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Registrar's Signature

DHMH 17 Rev 1/2001

920 Market Street, Denton, Maryland 21629

DO047534

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:00 Voloshina O Medical 4a. Facility Name (if not institution, Town, or Location of Death Examiner City, 4c. County of Death 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 03, 1 5. Social Secunty Num 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours Min. Country) Russia **Director** 344-90-4052 80 Dec. Usual Residence of Decedent oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **3615 Fords Lane #502** 21215 Russia 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 72 hours after 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. larked other than Elementary/Seconday (0-12) be filed within College (1-4 or 5+) Seamstress Textile Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Chistyakov Petukhova Baltin.

permit. Page 1 and 2 should by and Memory of Health and Memory of Health and Memory of the memory of the Tatyana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fords Lane #502; Baltimore, MD 21215 Lev Voloshin / Spouse Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/13/2010 Parklawn Cemetery Rockville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute M01463 1040 Rockville Pike, Rockville, MD 20852 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest short, and here fail re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ schemic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copyribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a. Was an autopsy After this certificate completed filled in by the funeral director, Be 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Hospital: 2 No 은 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \sum Yes 2 \sum No injury 5 Pending 1 Natural
2 Accident
3 Suicide death. Investigation after death Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

SS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Day Oscar Valentine May 6, 2:51 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months (Month, Day, Year) pt. 5, 1920 1 XM 2 F Hours Country) D.C. Director 578-18-0547 ept. Usual Residence of Decedent or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Blue Smoke Drive 20879 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married 1 X Yes 2 □ No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Black WWII 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 lith and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Valentine traumatic Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shi Department of Health an Important: If item 27 is any injury or other trau once. Mary Valentine/Wife 8800 Blue Smoke Drive, Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1x Burial 2/ Cremation 3 Removal from State cemetery, crematory or other place) 5 Cher (Specify) 4 Donation Fort Lincoln Cemetery Brentwood, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Septic Shock disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam death certificate be executed Pneumonia that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician a be detached for use as the burial-Physician/Medical If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ law requires Hypertension, Acute Renal Failure 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a Was an 24b. Were autopsy findings available autopsy performed? prior to completion of cause of death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 🙀 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

SIREESHA

31. Date filed (Month, Day, Year)

Thurs

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

JALLZ

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

9901

31. Registrar's Signature

000 680 EN

MEDICAL CENTER DRIVE, RUCKUILLE MD 20850

29d, Date signed (Month, Day, Year)

05/06/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per Fh G904 6/11/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 10,2010 Maurice J. Williams 8:40am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Security Number 10-1894 12-1638 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 ★ M 2 □ F v 13,1920 Hours Director 89 Canada Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director FLSt. Pete Beach 1 Xyes 2 No Pinellas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3760 Belle Vista Drive 33706 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ğ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Foreign Service Officer Us Dept of State is marked other aumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 27 is marker Alfred Williams Yvonne Theberge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Dunn Williams/ Wife 3760 Belle Vista Drive, St. Pete Beach, FL 33706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Inportant: If its any injury or of once. 1 Burial 2 XCremation 3 Removal from State National Crematory May 17,2010 4 Donation 5 Other (Specify) Falls Church, VA 22. Name and Address of Facility Joseph Gawler's Son, INC 5130 Wisconsin Ave, N.W. Washington DC 23a. Part 1. Enter the dis-ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Complications of Fall Medical resulting in death) Due to (or as a consequence of): Examiner α_{M} Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) After this certificate has been signed by the atter funeral director, page 2 should be detached for I in the past 12 months? Pregnant at time of death Month Day Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by Smoker Records, 1x Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Bronchitis 24a. Was an autopsy Were autopsy findings available prior to completion of cause of performed? Yes 22 No death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 X Yes 2 □ No Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural 5 Pending 2 Accident 4 2010 Tripped and Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number City or Town, State) 4 Homicide determined building, etc. (Specify) Home To the Hospital or within 24 hours a To the Funeral D cheuy Chase mo 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only or 29b. Signa 29c. License number 40 D42181 May 11,2010 30. Name and address of person completed cause of death (Item 23a) (Type, Print) Enrigue Daza, M.D. 8600 Old Georgetown Rd, Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature 14 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 10 2010 Sally Watnik 9:05 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bedford Court Nursing Home Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8 Date of Birth 1 🗆 M 2 🔀 F Hours New York Director 054-20-5632 Usual Residence of Decedent ural", or items 23a or 28a-f show | Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 01ney 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral P.O.Box 784 20830 United States hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2🛣 No Caucasian "natural", Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) 4 Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is merany injury or other? Abraham Goldberg Ruth Ratnofsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alicia Mahmot/Daughter 7424 Cinnabar Terrace, Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Crematory 5/17/2010 Brentwood, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute M01463 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Inter the disease, or complications that caused shock of heart failure. List only one cause on each line. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ Ovarian Carcinoma with local metastasis disease or condition resulting in death) month Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death been signed by the a should be detached f 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Deep venous thrombosis of leg Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? Cerebrovascular disease 24a. Was an page 2 performed? Yes 2 K No certificate Essential Hypertension 1 ☐ Yes 2 ☐ No within 24 hours after death.

• the Funeral Director: After this certific completed filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛂 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural injury work? 1 Yes 2 No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 1 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23958 5/12/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Burt Feldman,

32. Registrar's Signature

3305 N. Leisure World Blvd. Silver Spring, MD 20906

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month Mau Abraham T. Woldou 6:00р м 11 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 9. Birthplace (State or Foreign Country) Eritrea Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. Director 578-11-1826 53 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maruland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 Thayer Avenue 20910 u.s.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force ·Black, White, etc. þ 1 Never Married 2 X Married 1 Yes : 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced Specify: Completed Black Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Broker Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ should be Woldon Tesfay Roman Kidane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Silver Spring, Amleset Abraham - Spouse 700 Thauer Avenue. Maryland 20910 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I cemetery, crematory or other place) 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Important: If injury or 4 Donation 5 Other (Specify) of Heaven Cem. 05/15/2010 | Silver Spring, MD 21. Signa of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Inset and Death Physician/ disease or condition resulting in death) Liver Cancer ears Medical Due to (or as a consequence of) Examiner Hepatitis Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year Yes 2 No the detached 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the sign of the sign 23e. Did tobacco use contribute to the cause of death? Completed by Extensive Peritoneal Carcinomatosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has performed? Yes 2 2 N 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident
Suicide Investigation 1 Tes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 1 within 2 To the 1 only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) samely D 0065485 212010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 1500 Forest Glen Road, Silver Spring, Maryland 20910 Barbara Supanich, 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** 2010 ma /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give s aty of Deat Examiner atonsy1 ria Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Min Year. Months 63 1 □ M 2 🕻 F -8435 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show Department of Health and Mental Hygiene.
Important; if Item 27 is marked other than "natural", or items 23a or 28a-f shot any Injury or other traumatic event, if a five dical Examinating in the multiple at 1 XYes 2 No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 hours after death with Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 M No Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene ant. If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Be orman ပ 19b. Mailing Address (Street and Number or Informant's Name/Relationship 4nthon Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ha C Greene National
Baltimore National 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANCREATIC **Physician** METASTATIC ADENOCARCINOM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence offs The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Yea Month in the past 12 months? Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown ģ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 2**2**No 1 ☐Yes 2 ☐ No 1 □Yes Division of Vital Hospital or Attending Physician; 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital Other: 4MNursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral (28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier **Medical** (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MiD D059107

DHMH 17 Rev 1/2001

State Registrar 31. Date filed M

DRIVE

CENTER

REISTERSTOWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BUSINESS

32. Registrar's S

210

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Catherine Edna Auburger May 2010 Medical 9:20 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dixon House Easton Talbot . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours Min. 5/25/1931 Mary land 215-28-0321 Director 79 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Talbot Easton 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 N. Higgins Street 21601 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔯 No Black, White, etc Completed by 1 Never Married 2 Married filed within 72 hours after If Yes, Give 1 ☐ Yes 2 X No Specify. White 3 X Widowed 4 Divorced Specify: Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Charles O. Winchester Florence Eder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12795 Peach Lane, Cordova, Maryland 21625 Janice L. Drake / Daughter permit. Page 1 and 3 Department of Healt Important: If item 2 any Injury or other Baltimore, or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Onation 5 Other (Specify) New Cathedral 6/4/2010 Baltimore, Maryland Simat re of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final months Physician, LympHoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Examine Due to (or as a consequence of): physician and the burial-trans Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 🗌 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 A Other (Specify) Living Director: After this completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Natural 5 Pending injury 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier **D3988**7 0601 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Suite 301, Easton, MD 21601 Smith, MD 8221 Teal State 32. Registrer's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per Fig. 6904 6/15/10/TT
State of Maryland / Department of Health and Mental Hygiene

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			1 - State Registrar	Certificate of E	Death	R	Reg. No.			
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Sarah Gertru	ude Becker		2. Date of Deat Month May	Day 2 Year 2010	3. Time of Death 9:25P M		
	Examin		4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Care Ctr.		Location of Death more City	7	4c. County of Death			
	Funeral Director		5. Social Security Number 5 6. Sex 1 M 2 XF 68 Usual Residence of Decedent	oirthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, April	Year) - Count	place (State or Foreign try) yland		
	e Maryland r 28a-f show notified at	Director	10a. State 10b. County 10c. City, Tow MD Baltimore	wn or Location			Dundalk 10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
	h with the	Funeral [10e. Street and Number 7830 Lockwood Road	10f. Zip Code	1222		10g. Citizen of What Country? United States			
0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	13. Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e Specify: Wh			
Baltimore, Maryland 21215-0036	vithin 72 ho glene. er than "nat the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Years	6a. Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired) Nurse's Ai	uring most of work	ng	16b. Kind of Business Inc			
/land :	d be filed vental Hyg Mental Hyg Irked othe	To Be	17. Father's Name (First, Middle, Last) Raymond J. Celio		18. Mother's Name	e (First, Middle, M				
, Man	nd 2 shoul ealth and I m 27 is me ner traums		Irvin L. Becker, Jr. (Son) 7	9b. Mailing Address (Street a 7830 Lockwood	nd Number or Rura Road Di	Route Number, undalk,	Marviland	Code) 1222		
timore	t. Page 1 a rtment of H rtant: If ite rjury or oth		1 Burial 2 Cremation 3 Removal from State cemete 4 Donation 5 Other (Specify)	of Disposition (Name of tery, crematory or other place top Service C	e) i	5/2010	20c. Location - City or To Towson, Ma	,		
Ra	permit Depar Impor any in		21. Signature of Funeral Service Licensee	22. Name and Address Duda-Ruck 7922 Wise			Dundalk, Ind Maryland 21	c. 1222		
_I	Physician/ Medical Examiner		23a. Part 1 Enter the disease, or complications that caused the death. Do shot, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Transitional (Due to (or as a consequence)	Cell Carcinom				Approximate Interval Between Onset and Death		
8'	kecuted nand al-transit	Examiner	Sequentially list conditions, if any feeding to imple the cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen							
09/80	certificate be executed inding physician and use as the burial-transi	Medical	d							
. Box 68	To the bospital or Attending Physician: The law requires that the death certificate be executed within 24 h. urs after death. within 24 h. urs after death. The Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	ath 3 ☐ Ectopic pregnancen 5 ☐ Other (specify)	у		23d. Date of delive Month	ery Day Year		
S, P.O.	uires that th	þ	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause give	en in Part I.		pacco use contribute to the			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death, within 24 h, uns after death. within 24 h, uns after death. completed filled in by the funeral director, page 2 should be detached for use the funeral by the funeral director, page 2 should be detached for use the funeral director.	Completed				24a. Was ar autops perform 1 \(\sum \) Yes	y prior to cor ned? death?	osy findings available impletion of cause of		
lta l	rsician;	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/O	Othe	ace of Death (Check	only one)				
on or	ending Phy sath. or After this h≁ funeral c	Certificate: T	27. Manner of Death 1 🖾 Natural 5 🗆 Pending 2 🗋 Accident Investigation 28a. Date of injury (Month, Day, Year)	Time of 28c. Injury injury work?	at		nce 6 Other (Specify) w injury occurred			
DIVISI	ital or Atturs after de ral Directo lled in by ti		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fi building, etc. (Specify)			City or Town				
	the Hosp nin 24 hur the Fune	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/	d/or investigation, in my opinio	 n. death occurred at 	the time, date an	d place, and due to the cau	se(s) and manner stated		
þ			29b. Signature and title of certifier		To 82	2	29d. Date signed (Month, Day, Year)			
	0		30. Name and address of person who completed cause of death (Item 23a) Bruce Leff, M.D. 5505 Johns Hopk	(Type, Print) kins Bayview	Med. Ctr.	Baltin	nore, Maryla	nd 21224		
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registy's Signature	A. bares						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical РМ Alice M. Byrnes May 2010 1:14 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4315 Harcourt Road Baltimore Social Security Number Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday, 8. Date of Birth **Funeral** (Month, Day, Year 09-16-1922 Days 1 M 2 X F Director 87 <u>219-16-7795</u> Usual Residence of Decedent 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at or 28a-f 1 X Yes 2 No Baltimore N/A Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21214 5618 Winthrope Avenue permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 🗓 Widowed 4 🗌 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Aerospace** Clerical Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ (Unknown) Weronika Mikel Poturalski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21214 4315 Harcourt Road <u> Judith Horst - Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burlal 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 06-02-2010 Timonium, Maryland Dulaney Valley Memorial 21. Signature of Faneral Servide Ligensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the diverse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Retween Onset and Death Immediate Cause (Final Physician/ Debility disease or condition Medical resulting in death) Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or finjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Dav Year ned by the a e detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performe 2 🗌 No Yes 2 No 1 🗌 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗡 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at ter death. irector: After tl Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director, A
completed filled in by the f Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 🛄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) R149194 29,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles, Baltimore Marian Gat 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar UN 02

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b, per FH G904 6/2/10 TT State of Maryland / Department of Health and Mental Hygiene
	1 - For State of Maryland 7 Department of Health and Merital Hygierie 2 0 1 0 1 6 9 2 5
Physician/ Medical	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2. Day 2. Or 32. DAM No. 1, 1, 2, 3, 1, 1, 2, 3, 2, 3, 3, 1, 2, 3, 3, 1,
Examiner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1 An Vereity Of Many land Medical Ctv Baltinore 4c. County of Death
Funeral Director	5. Social Security Numtler 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 7. Age (In yrs. last birthday) 1 M 2 F 7. Age (In yrs. last birthday) 1 M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 9. Birthplace (State or Foreign Country) 1 Months Days Hours Min.
rland f show	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
he Marylanc or 28a-f shc e notified at	MD Baltimure Kandallstown 10e. Street and Number 10g. Citizen of What Country?
leath with the leath with the learn state er must be	9811 Clanford Road 31133 USA
9 E.S	1 Never Married 2 Married 1 Ves 2 No
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Examono. To Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life-10 NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+)
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rylan buld be fil d Mental marked of matic ev	19a. Informant's Name/Relationship (Type, Print) / 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
i, Ma nd 2 sho ealth an m 27 is ier traus	Margaret E. Beard/Wife 9811 Clanford Road Randallston, MD 21133
more age 1 ar ant of H it: If iter y or oth	20a. Methodol Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of permetery, crematory or other place) 1 Donation 5 Other (Specify) 20c. Location - City or Town, State
Saltir ermit. P. bepartme mportan iny injurince.	21. Signature of Funeral Service Licenspee 22. Name and Address of Facility Vargan C. Greenk Puneral 5 rrices
E E E E E E	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause at each line. Approximate Interval Between
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Examiner	Due to (or as a consequence of).
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38760 rtificate ling phy e as the	IF FEMALE: 23b Was decedent pregnant 23c. If yes, outcome of pregnancy 23d Date of delivery
Division of Vital Records, P.O. Box 68760 rate or Attending Physician: The law requires that the death certificate by stafer death. In price for Affart Itis certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the Lagrange of the formulate. To Be Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1
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rds, equires een sign hould be	ACUTE LEVKEMIA 1 Yes 2 No 3 Probably 4 Aunknown 24a. Was an 24b. Were autopsy findings available
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ivision of or Attending P after death. Director: After tin by the funera	1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined determined solution. At home, farm, street, factory, office 281. Location (Street and Number or Rural Route Number, 282. Place of Injury - At home, farm, street, factory, office 285. Location (Street and Number or Rural Route Number, 285. Description of the Company of the
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but Medical Certificate: To Be Completed by Physician/Medical	
the Hospital in 24 hours the Funeral inplated filled	
With	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 167977 6291 May, 28 th , 2010
9	Julyan Mulls 167977 6291 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tiffany Morton 22 South breeine Street Bultimore; MD 2120
State Registrar	31. Date filed (Month, Day, Vear) 32. Figistrar's Signature 11 N O 2 2010
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	ORIGINAL

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		•	For State Registrar			,	Cen	tificate of L	Death		Reg. No		N	c 2 0 -		
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980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status	ried 2 🛭 Married	12. Was Decedent Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates.	Ever in U.S.	1		lispanic Origin? (S) an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		14. Race - Am Black, Wh		dian,		
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Baltimore,	ge 1 an t of He If item or oth		20a. Method of Dis	sposition	Removal from State	20b. Place of	Dispos y, crem	sition (Name of atory or other plac	ce)	Date	20c. L	ocation - City o	or Town, S	State		
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Ĉ	Physician/ Medical Examiner		23a. Part 1. Enter shock, or he Immediate Cause disease or conditi resulting in death)	art failure. List only (Final ion		d the death. Do note. STATIC a consequence of	GA			or respiratory a	arrest,		Inter	roximate val Between et and Death MoJTHS		
0	e be executed ysician and e burial-transit	Completed by Physician/Medical Examiner	Sequentially list c if any, leading to i cause (Disease o that initiated ever resulting in death)	erlying er linjury ets	C	a consequence o										
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	To t with To tl		29b. Signature and	JUSV	ms				oumber	I	29d. Date signed (Month, Day, Year) MAY 28, 2010					
	101		30. Name and add	COSGROVE	completed cause of	death (Item 23a) (PKINS HO	Type, P S ያነገ	rint) ML, 600 No	ORTH WOLF	E STREET,	BALT	more, A	14 21	1287		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Ruth Helen Bullock Mav 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fairhaven Nursing Home Sykesville Carrol1 5. Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Ye April 13 9. Birthplace (State or Foreign Country) Maryland **Funeral** Days 1 M 2 5 F Months Hours 95 Yrs Director 212-05-7212 191 Usual Residence of Decede should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov 10b. County 10a. State than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Carrol1 Sykesville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7200 3rd AVenue 21784 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Gas & Electric 12 <u>Secretary</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Theodore Huettel traumatic Elsie Wetzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph William Bullock Son 1140 DRiver Road; Marriottsville, MD 21104 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Meadowridge Mem.Park 6/5/2010 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Funeral Service M01050 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final neumonia Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? **Director:** After this certificate in by the funeral director, pag Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Acciden (Month, Day, Year) 5 Pending work 1 🗆 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and titl 29c. License numbe 29d, Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

of person who completed cause of death (Item 23a) (Type, Print)

645

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year tunato Drun de ♠ M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4h City Town, or Location of Death 4c. County of Death Brightview Assisted Living Catonsville Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🔀 M 2 □ F Months Days Hours Min. Director 070-14-9888 89 1920 Italy Nov. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Directo 1 Yes 2 No MD Baltimore Catonsville 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7 Maple Avenue **IISA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc. ō 72 hours after ۾ 1 Never Married 2 Married White 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene.

is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Self-Empolyed Contractor Construction and 2 should be filed. Health and Mental Hvo Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Dogali Brun del Re Cecilia Mion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Cecilia B. Abbott Daughter 54 Topside Way; Mill VAlley, CA94941 injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 5/28/2010 Baltimore, MD Donation 5 Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsvile, MD 21228 21 Signature of Funeral Service Dcen Part V. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Metastatic Cancer with Unknown Primare disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 To the Hospital or Attending Physician: The law requires Hacites 1 Yes 2 No 3 Probably 4 Unknown Completed tsophagitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autonsy Mellitus Diabete 2 No Yes 1 Yes 2 🗀 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? 4 □ Nursing Home 5 □ Residence 6 12 Other (Specify) Hospital: 2 No 1 Yes Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA hours after death.

neral Director: After this
d filled in by the funeral di this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending injury 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat 29d. Date signed (Month. Day. Year) D0053337 May 2 1.2010 who completes cause of death (Item 23a) (Type, Print) Seay Baltrung 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Leroy Edmund Boyd 05.31.2010 1:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner North Arundel Health & Rehab 313 Hospital Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 2 F 217.12.7372 85 09.27.1924 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f show the Medical Examiner must be notified at Millersville MD A.A. 1 Tes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 21108 U.S.A. 8049 Veterans Highway or itams 23a death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Folces: 1 Syes 2 No If Yes, Give Year or Dates: WW I filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 → No SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Furniture Upolster) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Pages 1 and 2 should be filed w then of Health and Mental Hygier tant: If Itam 27 is marked other it jury or other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Annabelle scholl Howard L. Boyd ဂ္ 19a. Informant's Name/Relationship (Type, Print) 8049 Veterans Highway, Millersville, Clara Boyd/Wife Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 06.02.10 Beltsville, MD 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA 21. Signature of Funeral Service Licensee MO1443 MD 21286 8717 Green Pastures Dr. BAlto., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? his certificate h 1 ☐ Yes 2 ☐ No 2 No of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 3□ DOA this funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural n 24 hours after death.

The Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29s Certifia completely (Check only one) To the vithin 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D-40521 5+1 SWITE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 Hold (TAL DRIVE DR OCHLANES EVEH BERNIE, MD 31. Date filed (Month, Day, Year) JUN 0 2 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 1904 of 2-10 Ayrd Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Larry Badgett Sr. 2. Date of Death 3. Time of Death Physician/ 2010 Year 10: 26 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNSHOPCIUS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 04 20 (Month, Day, Year) Min. Country) 59 MD Director 2-60-6252 iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21206 <u>4409 Moravia Rpad</u> Apt U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural", 3 Divorced Black Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry
MD State Department permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) of Corrections Correctional Officer 2yrs+ 2th grade 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy J. Badgett <u>John Paige</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 526 North Potomac Street, Baltimore, Larry Badgett Jr.-Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Park 5/29/2010 Woodlawn, King Signature of Funeral Service Licensee March Fyff West 4300 Wabash Ave, Baltimore, Md 21215 Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASCUD MATS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Didhetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months? Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown certificate has been signed by the irector, page 2 should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) director, of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 FR/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Mann of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury 1 Natural Division 1 ☐ Yes 2 ☐ No Investigation ☐ Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) in Baynew heel Cor Baltomore MD 32. Registrar's Signature State Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Boyd Month 3:45 A M Ursula 20 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Season Hospice Baltimore Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Min 1 M 2 SxF 220-74-5678 Director 62 Germany Aua Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Reisterstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Sugarbury Ct. 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than * any injury or other traumatic event, the Mea College (1-4 or 5+) Elementary/Seconday (0-12) Store Clerk Retail unk ukn Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Sugarbury Ct. Reisterstown, MD 21136 William McPhail/Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Final Journey Cr 5/28/10 Woodbine MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charisse N. Woods 2700 Edmondson Ave. Balto., MD F/S 21223 21. Signature of Funeral Service Licensee 23. Pirt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Breast cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p IF FEMALE: asn. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No 1 Yes 2 9 Unknown Linknown signed by d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy abed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be 6 Other (Specify) examiner? Hospital Other: 2 🗹 No 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending neral Director: Affilled in by the fur Accident 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ратыры Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MSRayapaksem.D 5/20/10 D0057465

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.0.

Records,

Division of Vital

2835 5 mith

32. Registrar's Signature

Av., 5-235 - Baltmore, MD. 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N-S. Rajapakse, M'D

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 10c, d per th g904 6-2-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16Day 3. Time of Death Month 5 BOTLEM Physician/ 0350 ALICE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death MONT GOMENY IASHINGTON Adventist AKoma ark If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 7-50-264 Hours Min. (Month, Day Director Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Hyattsville 1 X Yes 2 KINO 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 783 Funeral 20 26en7 5 110 , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. þ 1 Never Married 2 Married 2 No Yes Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.] 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) conday (0-12) College (1-4 or 5+) domestic ome ma Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 05 ۵, 55/2 Lando 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #1107 ArGent Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ntwood, ML INCO/D 4 Donation 5 Other (Specify) 21. Si nature 1 Funeral Service Lice Name and Address of Facility 19me masHDC. Soxs hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in each line. Part I. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Onset and Death Immediate Cause (Final HGART Physician/ UNGEST 14 PRIKUTH disease or condition resulting in death) Medical Examiner ATHEMOSILEMOTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Yes 2 🖳 No been signed by the should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 ☐ Yes 2 ☐ No pleted filled in by the funeral director, Be 25. Was case referred to medical Place of Death (Check only one) Hospital 2 No Other: မ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 \square Pending s after death. Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours 8

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -Nev Alcoma MD. RVINE 7600 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4 RNARD Mont Physician/ Medical City_Town, or Location of Death 4c. County of Death **Examiner** OCK VALLE MONTGOMER 8. Date of Birth Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under **Funeral** Min **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Nes 2 No HIL 10f. Zip Code 10g. Citizen of What Country? Funeral 20 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No ACK 3 Widowed 4 ADivorced Year or Dates. injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) POPRIETOR AXi Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna BARNARD ပ LARENCE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 745 19a. Informant's Name/Relationship (Type, Print) LINDA FlowER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ⊙ Other (Specify) 8-2010 BELTSVILLE, MO FUNERAL HOME V, DR. 20002 HENRY 21. Signalure of meral Service any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or pach line. Approximate Interval Between Onset and Death Immediate Cause (Final LANCER Physician/ disease or condition resulting in death) AS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last To the Funeral Director, After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? RILLATION 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes 2 \(\sum \) Yo Other: 4 Nursing Home 5 Residence Other (Specify) HOSPLF IPO မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No hours after death. Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

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State

30. Name and address of person

31, Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Mar			t of Healtr e of Deat			giene () () () () () () () () () () () () ()	16934
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/Medic Examin	100	4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Location	on of Death		4c. County of De	ath
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Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthday) If Under Months	1 Year If Und	der 24 Hrs.	8. Date of Bir	th 1000 9. B	irthplace (State or Foreign Country)
Director		172-28-8154	Ö M 2□F	80 Yrs.	MOTITIS	Days	13 141111.	Januar		
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vent	Be	17. Father's Name (First, Middle, Last)				18. Me	other's Nam	e (First, Middle	, Maiden Sumame)	
lc e	ToE	Eric H.	Biddle,	Sr.			Kathe	erine	Roge	rs
rauma	_	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ling Address	(Street and Nu	mber or Rur	al Route Numb	er, City or Town, State	, Zip Code)
other tra		Michael Biddle /	Nephew	13	245 Me	elville	Lane,	Chanti	11y, VA 2	0151
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compretery med in	Medical	(Check only 2 Medical Examone)	miner: On the basis of e and manner state		investigation	n, in my opinion,	, death occu	rred at the time	, date and place, and	due to the cause(s)
5	Me	29b. Signature and title of certifier	. 0		29	c. License num	ber		29d. Date signed (M	onth, Day, Year)
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		30. Name and address of person who				- 1	MI	20017		
		Kirti Bohra M.D.	//10 Br 32. Regist/ar	adley Bl			, MD	20817		
Sta	ate	31. Date filed (Month, Day, Year)	32. Hegistrar	a Signature	Bac	Kank				

DHMH 17 Rev 7/2009

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atural cal Ex	Completed by	3 🔀 Widowed		Year or Da		16a De	cedent's Usua					165 1		Whi		_
n 72 h an "n Medi	d m	(Spe	cify only highe	est grade completed) College (1-	-4 or 5+)	(Gir	e kind of wor DO NOT use	k done d		t of worki	ng	10D. K	(ind of Busir	iess ind	ustry	
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Page ment tant: I		4 Donation	5 Other (S	Specify)	F	inal Jo				y 6/3	3/2010	Woo	dbine	, Ma	ryland	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu		James James	МО	0957	22. Name an Going Beverl	Addres Home	s of Facility Cre Hec	matic krott	on Serv	ice . Cl	P.O. arksv	Box ill∈	784 MD 210	29
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e atte	Physician/M	in the past 12 p 1 Pes 2 2	No No		nant at time	Fetal death 3 of death 5	Other (sp		У				Month		Day Year	
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been should	Completed										24a. Was	an			sy findings availab	
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hysic this ce al direc	욘	1 ☐ Yes 2 ∑	₹ No			2 ER/Outpat		_	4 ∐ Ni		me 5 KResi			Specify)		
ding F h. After 1 funera	Certificate:	27. Manner of Death 1 X Natural	5 Pendin	ig .	of injury th, Day, Yea	r) 28b. Time injury		Bc. Injury work		- 1	28d. Describe I	now injur	y occurred			
Atten	ij	2 Accident 3 Suicide 4 Homicide	Investig 6 ☐ Could determ	not be 28e. Place		At home, farm,			165 2 [-	28f. Location (Street an	d Number o	r Rural I	Route Number,	
tal or		4 El Homodo	determ	buildir	ng, etc. (Sp	ecify)					City or Tov	vn, State)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		☐ Medical E	Physician: To the b xaminer: On the bas	is of examin	nation and/or inv	estigation, in I	ny opi <i>n</i> io	n, death o	ccurred at	the time, date a	and place	, and due to	the caus	se(s) and manner s	tated.
o the lithin 2 orthe lomple		only one) 3 29b. Signature and		Nurse Practioner:	To the best	of my knowledg			e time, date number	and place	e, and due to th		s) and manne te signed (N			_
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20/		30. Name and addre	ess of person	who completed caus												
Juv		D. Scot					in Ave	nue	Suite	e 930) Chev	y Ch	ase, J	Mary	land 208	15
State Registra	e	 Date filed (Mont) 		32. R	egistrar's Si	-	back	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Dav Year HERBFR **Physician** 2010 7.0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Baltimore FutureCare Irvington 7. Age (In yrs. last birthday) 72 Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 XM 2 □ F Director 12/28/1937 SC 251-58-3414 Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinal must convolited at Director Yes 2□No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4407 Towanda Avenue 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 TXNo Specify 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+ 8th Grade Construction Universal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Johnston Colvin Sallie Davis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tra Health em 27 i 4407 Towanda Ave., Baltimore, MD 21215 Louvinia Blackston (Wife) 20b. Place of Disposition (Name of cemetery crematory or other place)

Joseph Brown F/H
and Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 06/01/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph H. Brown Jr. Funeral Home, 2140 N. Fulton Ave., Baltimore, M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ellerosci disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death reguires that the death 3 Ectopic pregnancy in the past 12 months? Month Day ☐ Pregnant at time of death 5 Other (specify) □Yes 2□No the detached 9 ☐ Unknown by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law certificate has page 2 autopsy performe 2 🗆 No 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient After this of funeral din 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Ballinore M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGHMEID ij 32. Regis ar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month D641A Marie Chavis Medical 4a. Facility Name (if ηot institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death 0 N/A tel sumition Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 0471939 Director 217-38-3883 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/A 1 XYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3322 Hayward Avenue 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Good Samaritan (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home 11th Grade CNA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Purcell Bates Virginia Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tama Smith (daughter) 2533 Francis St., Baltimore, MD 21217 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Garrison Forest 06/09/10 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home, P 2140 N. Fulton Ave., Baltimore, MD como 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ schemic day s disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached Part II., <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Z Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 힏 2 No ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 1 Natural 5 Pending 1 Tes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 29 223 Ma 2010 M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUNIZEDDY MD SANJAY

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

MATIS

9

r's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 May 6:21 pM Frances Jean Coppersmith Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 37^{count}Maryland 216-34-9638 1 M 2 XF 73 Hours April 1, Y26, 19 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll 1 Yes 2 No Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26 Bella Vita Ct. Unit 3B 21157 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 💢 No Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72. In and Mental Hygiene. Is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter J. Warren permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Bertha E. Peltzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Mendenhall - daughter 3513 Oxwed Ct. Westminster, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June leasant Grove Ch. Cem. Reisterstown, MD. 22. Name and Address of Facility Eckhardt Funeral Chapel P.A 21. Signature of Funeral Service Licenses Kuto B296 Charmil Dr. Manchester, 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Non Quewe Ms Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Idennoch, Nom 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 A No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work within 24 hours after death.

To the Funeral Director: Al 1 Yes 2 No Accident Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier сотретер 3 Certifying Nurse Practione death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar DHMH 17 Rev 7/2009 cause of death (Item 23a) (Type, Print)

ela

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17.18 per inf e904 6-18-10 versitate of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Good Samaritan Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct 25, Birthplace (State or Foreign Country) Funeral Days Hours Min. 1 🗆 M 2 🔀 Director 83 Alabama 220-20-5640 Usual Residence of Deceden ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5604 Pioneer Drive 21214 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc o, 1 Never Married 2 Married Completed by 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 → Widowed 4 □ Divorced "natural", Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allen Osburn Evelyn Nona Guy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Carr /Son 5604 Pioneer Drive Baltimore, MD 21214 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Jun 02 4 ☐ Donation 5 ☐ Other (Specify) 2010 Beltsville, Maryland Chesapeake Crematory Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of) resulting in death) Last the attending physician thed for use as the burial Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STHMA. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown SINUSITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform within 24 hours after death.

To the Funeral Director: After this certificate becompleted filled in by the funeral director, page 1 🗆 Yes 2 🗆 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) 1 Natural work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titlé of certifie 29d. Date signed (Month, Day, Year) 29c. License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH PAVEN BUYD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sidney Curtis	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.	1694
Physician/ Medical Examiner	Gidnow D. Curtie Tr. Month Day Year 100	e of Death 24 hrs
Mealcal LAgillie	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	330 Herring Court Baltimore	
Funeral	5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM//DD/YYYY) 9. Birthplace Months Days Hours Min. Foreign	(State or
Director	218-60-4604 1 X 2 F 56 Yrs. 12-10-1953 Country)	MD
ny	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. In	side City Limits
ne Maryland or 28a-f show any fred at once.	MD na Balto	Yes 2 No
the Maryland as or 28a-f sho	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
h the N 3a or otified	330 Herring Court 21231 U.S.A.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1	an, Black,
ter dez	3 Widowed 4 Divorced If Yes 2X No 1 Yes 2 No specify: Specify: Bla	ck
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To with To con	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day	, Year)
	May 28, 2010	
\	30. Name and address of person with completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State		
Registrar		
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ester Creech	State of Maryland / Department of Health and Ment		2010 16942
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ospi hou y fill	29a Certifier	e, and due to the cause(s) and	manner as stated
To the H within 24 To the Fr	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.		
F 3 F 2	29b. Signature and title of certifier 29c. License number		ate signed (Month, Day, Year)
	Cielo Valler West O.C.M.E.	May :	31, 2010
	Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD	MD 21201	
Stat	31. Date filed (Month, Day, Year) 32. Registrar's Signature		

OCME

10-03708 Britney Candeloro Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Aa. Facility Name (if not institution, give street and number) University Hospital 5. Social Security Number University Number University Hospital 6. Sex 17. Age (In yrs. last birthday) 1	Foreign Country) Maryland 10d. Inside City Limits 1 XYes 2 No What Country? ace - American Indian, Black, hite, etc. by: White Business/Industry
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and manner stated 29c. License number 29d. Date signature and title of certifier	gned (Month, Day, Year)
(May 18, 2	2010
asing 10	
30. Name and address of person who completed cause of death (flem 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 🕕 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Walter M Cates 1750 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Manyland

5. Social Security Number 6. Sex Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 🛛 M 2 🗆 F Months Hours Min 212-42-9679 66 10//37/1943 Director NC Usual Residence of Decedent Fshow 10a. State 10c. City, Town or Location Director 10d. Inside City Limits er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified MD Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 740 Poplar Grove Street, Apt. 6E 21216 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
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any injury or ott 20c. Location - City or Town, State 1 🗆 Burial 2 💆 Cremation 3 🗆 Removal from State Final Journey Crem. 5/28/2010 Woodbine, MD 4 Donation 5 Other (Specify) Euneral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ SUPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ischemic small bowe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner burial-transit fulminant hopatic failure and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗌 No Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural injury 5 Pending Division ☐ Accident ☐ Suicide Investigation 1 Yes 2 No Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Tolo MD 1972792505 eurs-05/24/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S Baltimare, MD 32. Registrar's Signature State Knewa Registrar DHMH 17 Rev 7/2009

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amend 1 tem 30 Mer dw/Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year FRANK CHARTOVE MAY Medical 2010 .59 Λ 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A 1040 DEER RIDGE DRIVE BALTIMORE #103 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 **X** M 2 □ F 062-14-9921 Months Days Hours 05/09/192 89 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE 1XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1040 DEER RIDGE DRIVE, #103 USA Page 1 and 2 should be filed within 72 hours after death ment of health and Mental Hygiene.
ant If item 27 is marked other than "natural", or items unt or other traumatic event, the Medical Examiner muy or other traumatic event, the Medical Examiner muy or other traumatic event, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: 3 X Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALES TAX AUDITOR STATE OF MARYLAND Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ PHILIP CHARTOVE **ESTHER** GREENBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARA ELLEN CHARTOVE/DAUGHTER 14800 FOURTH STREET,#30C LAUREL, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) BETH TFILOH CEMETERY D5/30/2010 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MYOCARDIAL INFARCTION Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) MO FLD D0065557 5/27/10 30. Name and address of pers n who completed cause of death (Item 23a) (Type, Print) Martin EngelHardt 1838 Greentree Rd. #535 Baltimore, Md. 21208 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Physician/ Marina I. Cruz 2010 11:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 13 Ridge Road, Unit M Prince Georges Greenbelt Social Security Number If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Hours March I. 072-56-8191 88 Director Yrs. <u>Ecuador</u> Usual Residence of Decedent shov the Maryland notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD Prince Georges Greenbelt 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a13 Ridge Road, Unit M 20770 Ecuador permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 XYes 2□No Specify: Ecuadorian 3 X Widowed 4 Divorced Specify: "natural" Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Adalberto Dominguez Silvania Zambrano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Gorky A. Cruz, son 13 Ridge Road, Unit M Greenbelt, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ŏ 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Metro Crematory, Inc. 05/28/10 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb 8 M 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Dementia, Advanced Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No ō Pregnant at time of death Month Day the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Tyes Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) this To the Hospital or within 24 hours after death.
To the Funeral Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 & Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RUBA D23743 May 28, 2010 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Cntr Dr. Greenbelt, MD 20770 Martin D. Weltz, D.O., F.A.C.P. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year FREDERICK SOFM 05 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death **Examiner** SAMARITON HOSPita BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 69 Yrs. 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months Days 1**№**M 2□ F Director ruly 16. MARYLANO 1990 Usual Residence of Decedent the Maryland State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modey Examinations to notified at gones. Funeral Director Altimore 1 XYes 2 No MARYland Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Winston 21212 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specity: If Yes, Give Year or Dates 1 □Yes 2 PNo Specify. þ 3 Widowed 4 Divorced AMERICAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kin of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinery Cleaner and 17. Father's Name (First, Middle, Last) Be should be ဂ္ဂ Stalling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Pages 1 and 2 Winston AUE - BAHIMORE, MARYLAND 21212 John Hancock Itimore, 20b. Place of Disposition (Name of cemeter), crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 4, 2010 BAHIMORE MAR 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Simplifier of Funeral Service License 13405 W. FRANKLIN Steet BALTIMORE 22. Name and Addre Maure land 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HEART disease or condition resulting in death) CONGES TIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any could be conditioned as cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consectiones of) the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn certificate 1 ☐ Yes 1 ☐ Yes 2 🗆 No 25. Was case referred to nedica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral Detely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Sal (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J-6-A Respoo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASSI 500 LOCH RAVEN BLUD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pay 2010 Physician/ 00:14 4 **COLL ECTOR** BERNARD Medical 4b. City, Town, or Location of Death Facility Name (if not institution, give street and numb 4c. County of Death Examiner N/A salt mas If Under 1 Year If Under 24 Hrs. Sex 1 M 2 D F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Country) ٧A 0471871916 215-01-6346 94 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director or 28a-f sl notified 1 Tes 2 X No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? "natural", or items 23a o Funeral 21208 USA 9050 IRON HORSE LANE, #327 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 WHITE 1 ☐ Yes 2X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates ntal Hygiene. ted other than "natura event, the Medical E Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry 3 (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) WHOLESALE APPLIANCES SALESMAN is marked other Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 **JOSEPH** COLLECTOR BESSIE SALTZMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9050 IRON HORSE LANE, #327, BALTIMORE, MD ESTHER COLLECTOR/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State TIFERETH ISRAEL CEM. 6/1/2010 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 1 No 1 Tes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: မ 1 Yes 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fune completed fi Wedicah Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner as stated. (Check dertify only on 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) RES-000 an who completed cause of death (Item 23a) (Type, Print) ark, MD Sinai Hospital of Baltimure ss of p

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State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 10:05 PM **Physician** Dennis May Eugene 26 2010 Alauin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country)
 PA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 173–38–1561 **Funeral** Days 1**XX**M 2 □ F 63 9/23/46 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a array injury or other traumatic event, the Mariana. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location PA Lackawanna Eynon 1 X Yes 2 No Director 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 110 First Street 18403 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: white 1 ☐ Yes 2 No Specify Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Alquin Dennis Be Mable Trimble ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 110 First Street, Eynon PA Susan Dennis / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6/1/2010 1 ☐ Burial 2 ☐ Cremation ③ Removal from State Jermyn Cemetery Jermyn PA 4 ☐ Donation 5 ☐ Other (Specify) Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 or Funeral Service Licensee Victor P. Doda Signa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) preumonia /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical detached for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No 2 No 1 ☐ Yes 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 2 No 2 - ER/Outpatient 1 Tes 1 Inpatient 3 🗌 DOA 4 \Bullet Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funeral 27. Manner of Death Certification: 1 Natural Injury 5 Pending 1 TYes investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) ertifier 29c. License number 29b. Signature and title RES 26 2010 d address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 70 Follars 31. Date filed (Month, Day, Year)_____ 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Helen Bertha Derka Medical May 2010 11:30 PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Center Timonium Baltimore Co. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth 1 □ M 2 🔽 F Months Days Hours Min (Month, Day, 220-22-8486 Director Sept. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Middle River 1 ☐ Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 2008 Oakland Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married within 72 hours after 1 Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 x No Specify: Completed 3

Widowed 4 □ Divorced Specify. Year or Dates White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 3 Years Homemaker Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) of Health and Mental H if item 27 is marked ot r other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) ည Tilly Mileuska William Novak 2010 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Jeanette Elza (Daughter) 2008 Oakland Road Middle River, Maryland 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other placel 1X Burial 2 Cremation 3 Removal from State 5/26/2010 Oak Lawn Cemetery Baltimore, Maryland 4 ☐ Donation, 5 ☐ Other (Specify) permit. Signature of Juneral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of 7922 Wise Ave. Dundalk, N Dundalk, Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition END STAGE RENAL DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the k IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknown 9 Unknown signed by t d be detach HELEN Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 No certificate death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2**X** No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Investigation 1 Yes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 **X** 5 29b. Signature and tity 29c. License number 29d. Date signed (Month, Day, Year) 2010 ress of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM. MD 21093 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D201<u>0</u> Physician/ May 14 9:20 PM David Hollis Dunham Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bethesda Suburban Hospital Montgomery Funeral 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Birthpi-Country KY 1 🛣M 2 🗆 F 5 (M27/1950 ear) Director 412-88-2527 60 Usual Residence of Decedent Show 10c. City, Town or Location 10a. State 10b, County within 72 hours after death with the Maryland 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 😾 Yes 2 🗌 No TN Davidson Nashville 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 2116 Hobbs Road, 37215 USA Apt I-212. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Representative Architectural Specs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bonnie Redmon Walter Carlos Dunham 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Castlegate Drive Nashville, TN Elaine Said/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 5/21/2010 4 Donation 5 Other (Specify) Alexandria, Virginia Metropolitan Crem. 21. Signature of Fu eral Service License 22. Name and Address of Facility Marshalls Funeral Home Washington. 20011 217 Ninth Street, NW Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Day Immediate Cause (Final Physician disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner 1 Day Pneumonia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Uause (Uisease or injury Due to (or as a consequence of) that the death certificate be executed 5 Days Neutropenia sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical 7 Years Chronic Lymphocytic Leukemia Division of Vital Records, P.O. Box 68760 as the IE FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown a Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy pérform certificate 1 Ves 2 □ No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗹 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director; After 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital of 24 hours at Euneral D Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 8909 NF May 20, 2010

Registrar
DHMH 17 Rev 7/2009

State

Bethesda, Maryland

10 Center Drive,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Bishop, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Domiciana de Macedo Dias 3:02a Mav 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Chesapeake Hospice Tate House Linthicum Heights If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Brazil 8. Date of Birth **Funeral** 1 🗆 M 2 🖾 F 217-60-0914 March 25 Director 97 ື 1913 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location the Maryland 10d. Inside City Limits Director 1 Yes 2X No Maryland Linthicum Heights Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 Oak Grove Road United States 21090 within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72, and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frederico de Sousa Dias Messias Macedo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a <u>MariaRuth Steffen, Daughter</u> Oak Grove Road, Linthicum Heights. MD 21090 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Cemetery Ellicott City, Maryland June 2, 2010 22. Name and Address of Facili MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Licensee Amanda Heaston 301 <u>Frederick Road, Catonsville, Maryland 21228</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence bi) trany leading to immedicause. Enter Underlying Cause (Disease or iinjury Examir Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Jo in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death
Unknown signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? Yes 2 No 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Sp. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WILLIAM Delost. Sr. Physician/ Month Dav Year 10: 30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore-Washington Medical Center Glen Burnie 7. Age (In yrs. last birthday) 75 yrs. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sev 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-32-3757 Days Hours 1 🕱 M 2 🗆 F December 6, 1934 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Curtis Bay 1 X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1611 Locust Street 21226 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) W.R. Grace & Company Forman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Anna Zulkie ပ Frank DeLost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. De Lost Jr. 1049 6th Street, Glen Burnie, Maryland 21060 (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Cedar Hill Cemetery 1 X Burial 2 Cremation 3 Removal from State June (33, 2010 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cully Polyniak Funeral Home P.A. 237 East Patapsco Avenue, Baltimore, Maryland 21225 21. Signature of Fundal Service License 23a. of 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate mediate Cause (Final Onset and Death Physician/ ancreation sease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a nsequence of) Examine if any, leading to immediate cause. Enter Underlying ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 5 Other (specify) led by the a detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 2 😾 No Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director; After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 2 1 No 1 🔣 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 \square No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner To the best of my knowledge distributions determed place, and due to 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. G. len Burnie, MD Hospit 301 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Leona Evelyn Dorbert 1:25 PM 2010 May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death 917 Wakefield Dr. Havre de Grace Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Marylan d 1 M 2 XF Min. (Month, Day, Year) 118/1954 Director 218-58-6993 56 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director Yes 2 No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 917 Wakefield Dr USA 21078 within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married <u>\$</u> 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes X No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ral Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 School Bus Driver Education 0 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o May Catherine Greaver Elmer Frank Ulbig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 917 Wakefield Dr, Havre de Grace, MD 2 1078 George Dorbert, Sr/Spouse Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State West Chester, permit. Page 1: Department of h any injury or Ferris & Co. 6/2/2010 4 Donation 5 Other (Specify) . A . Pennsylvania Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ METASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Saguentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔏 No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the and be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? Yes 2 X N 2 🗆 No 1 Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 2X No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director, After 1X Natural 5 Pending work? 1 Tes 2 🗌 No Accident Investigation filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi June 1, 2010

Registrar
DHMH 17 Rev 7/2009

State

Michael HUERB, 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh e904 6-4-10 vt. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05^{Month} Maurice W. Eley 2010 4:25p [№] Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 24 Mountain Green Circle Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, 1 1 □**X**M 2 □ F Days Hours Min Director 50 214-56-7278 MD Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Baltimore 1X Yes 2 ☐ No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 Mountain Green Circle 21244 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 XMarried þ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4yrs+ 12th grade Federal Employee Team Leader Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked or permit. Page 1 and 2 should be a Department of Health and Mental Important: If item 27 is many injury or otheren. ၉ Ralph Elev Ida Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 Vera Veva P. Ham-Eley-Wife Mountain Green Circle, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) On-Site 6/3/2010 |Baltimore, Md 21. Signature of Puneral Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Ave Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ dical Onset and Death disease or condition resulting in death) hiner ME DIABSTE Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Antsny 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen HYPSNTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an is certificate has director, page 2: autopsy performed?

1 Yes 2 No death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 ☐ Yes ပ္ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending I Director: A 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined nin 24 hours at the Funeral D mpleted filled Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier m. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRIKUNIE.D. (LOVA, Ste 344) ZHAMILLRO, BATILMONE, IBIKUMLE 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical William Francis Fitzpatrick 2010 6:10 AM 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Ivy Hall Geriatric Center Baltimore Middle River Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Hours Min Maryland Director 10/10/1914 218-09-9992 95 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore 1 Yes 2 X No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1521 Nicolay Way 21221 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No o by Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 "natural", 3 Widowed 4 Divorced If Yes Give 1 ☐ Yes 2 X No Specify. Completed Specify: Year or Dates White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 8 Alarm Mechanic / Inspector Alarm Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ (Unknown) Fitzpatrick Mary Noonan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mae Fitzpatrick (Wife) 1521 Nicolay Way Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place injury or 267o 4 Donation 5 Other (Specify) Meadowridge Memorial Park Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Fastern Avenue PA Essex, Maryland 21221 20 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death Dreumonia disease or condition resulting in death) ree Medical Examiner Due to (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ ρ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Yes Dav Year detached 1 ☐ Yes 2 L 9 ☐ Unknown rate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy
performed?

Yes 2 XNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital မ 1 Yes 2 X No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending Accident work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (UV 1124 Mace Due Batto, MDZ/ZZ/

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

JUN 0 2 2010

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 9:40 AMM Philip May Raymond Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Towson Baltimore Gilchrist Center for Hospice 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 □ F Davs Min. 2/5/1944 **Director** 212-46-1886 66 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Baltimore Maryland Essex 10f. Zip Code 10g. Citizen of What Country? Funeral 426 Lorraine Avenue 21221 S. Α. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 ☐ Never Married 2 🏋 Married 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced Vie<u>tnam</u> Year or Dates. White event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than, Elementary/Seconday (0-12) College (1-4 or 5+) Radar Electronics Technician 12 Aero Space is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Amelia Friedel Fisher Louis George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Donna Denise Fisher (Wife) <u>426 Lorriane Avenue Essex. Maryland 21221</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 2610 4 Donation 5 Other (Specify) of Faith Mem. Gard Overlea, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ INTRACRANIAL HEMORRHAG MARCH 2010 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) and I-transit requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 4 ☐ Pregnant g ☐ Unknown g Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STROKE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ISCHEMIC CARDIDMYOPATHY 24a Was an performed? Yes 2 No or Attending Physician: The this certificate 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Yes 2 □ No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu MARCH 18, 2010 KNENOWN M 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined SUBACUTE REHABILITATION FACILITY To the Hospital o within 24 hours af To the Funeral Di EASTERN BLUD Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D64395 MAY 31, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUR DOBERMAN, MO 6701 NCHARLES ST. 8NITE 4105 BALTIMARE, MO 21204

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09:28 AM NZEL ON Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death timore last birthday) **Funeral** If Under 1 Year Birthplace (State or Foreign Country) 216-90-503 1 □ M 2 **X**F Months Director 10a. State within 72 hours after death with the Maryland notified at 10b. County 10c. City, Town or Location Director 10d. Inside Cify Limits 28a-f 4 more 1 Yes 2 ☐ No 10e. Street and Numbe ò 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 21223 Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, ò ģ 1 Never Married 2 Married Black, White, etc. Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black "natural", Completed 3 Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Ind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Sedonday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the my injury or other traumatic event, the one. Be ည State, Zip Code) Baltimore, Method of Disposition 20b. Place of Disposition (Name of 1XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ Accest ardiac disease or condition Medical resulting in death) Examiner ハハス cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Month Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 sl 24a. Was an autopsy performe Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital ٥ 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending hours after death. Ineral Director: A 2 No 1 Yes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number . Mikdashi 0038046 5/29/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore street Bultmore MD 21223 2000 Nik Jashi mo 32 Registrar's State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

71	(3)
State of Maryland / Department of Health and Menta	al Hygiene

			For 1 _ State	State of Ma	ryland	•	artment of F				16939
			Registrar 1. Decedent's Name (First, Middle, Las	w)		Cei	uncate or i	Jeani	2. Date of Death	g. No.	3. Time of Death
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	D .		Usual Residence of Decedent								T
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Ĕ	or Atter de irecte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc	ry - At h <i>o</i> r . <i>(Specify</i>	me, farm, str	reet, factory, office		28f. Location (Str City or Town,		Rural Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Exag	ysician: To the best of	examinat						
	thin 2 the	Med	one) 29b. Signature and title of certifier	and manner sta	tea.		29c. Licens	se number	29	d. Date signed (Mo.	nth, Day, Year)
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State Registrar

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Physician/

Medical

Director

Funeral

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permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical Jonce.

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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	20a. Method of Disposition 20b. Place of Disposition 1 Burial 2 X Cremation 3 Removal from State	isposition (Name of crematory or other place)	Date	20c. Location - City or	Town, State
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ļ	21. Sign / Jure of Funeral Spice See	22 Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy.	Funeral Ho SE; Glen	ome, P.A. Burnie, MD	21061
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care.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 28a. Date of injury (Month, Day, Year) inju		1	w injury occurred	
i cerundate.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (St. City or Town	reet and Number or Rui , State)	ral Route Number,
Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in the basis of examination and the basis of examinatio	vestigation, in my opinion, death occu	urred at the time, date an	d place, and due to the	cause(s) and manner stated
	29b. Signature and title of certifier A JAY GAN A JAY GAN M.D.	GA LA 1990. License number	1296 2	9d. Date signed <i>(Montt</i>) 5 / 27 / 2010	n, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type 9000 Franklin Square	pe, Print) Rosedale	MD 2	1237	
e r	31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	hadl		10 10	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygiene [] | [1 - State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician/ 16.04 eward Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner MOV 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min. Mayonth, Day 9333 WesteryVirginia 1 🖾 M 2 🗆 F 235-50-0255 77 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County death with the Maryland 10a, State Director 1 ☐ Yes 2 🎽 No Ellicott City Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21042 USA 4028 Jumpers Hill Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1954—
If Yes, Give Black, White, etc. 1 Never Married 2 😾 Married 'natural", or b Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 1962 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) animal care veterinarian 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Beatrice Marie Hollman Steward Howard Frazier Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4028 Jumpers Hill Lane; Ellicott City, MD 21042 Jean Evansmore/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ₺ Donation 3 ☐ Other (Specify) 21. Signatur 1 uneral 22. Name and Address of Facility Board; 655 W. Baltimore Street Baltimore. Maryland 21201 25a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Causa (Final Physician/ Introcranial disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to for as a consequence of) Examin Cause (Disease or linjury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of) attending physician for use as the burial CERTIF Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicial leted filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Multiple myeloma 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an F. brillation autopsy performed: death? 1 ☐ Yes 2 📈 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔲 No 1 X Inpatient 2 ER/Outpatient 3 DOA ျှ Date of injury (Nagth, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural
2 Accident 730 fM work? 1 ☐ Yes 2 💆 No 5 Pending -Z010 Investigation 9 1.6 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) LICZ & Jumper HILL LA completed filled in by determined mD OME Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the P within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE ST Baltimore. III Halonen 22 Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland					- L	010	165	352
			State Registrar 1. Decedent's Name (First, Middle, La	not)	C	Certificate of L	Jeatn	2. Date of Dea	Reg. No.		3. Time of D	eath
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	/Medic Examin		4a. Facility Name (If not institution, gir			4b. City, Town, or	Location of Death			ty of Death		
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	r dea	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S.	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No p Rican, etc.)	Bla	ace - Americ ack, White,	etc.	
5-0036	be filed within 72 hours after death with the Marylar the Hydione, and Hydione, other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No				_{ify:} whi		
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yland	lid be lental rked c iic ev	To Be	Frederick Augus	t Neimiller				et Irene				
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on	Attending Physician: r death. ector: After this certifica by the funeral director, I	tion	1 ✓ Natural 5 ☐ Pending investigat	(Month, Day Year)	In		Yes 2 No					
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	To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Co	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of my kno caminer: On the basis of examina and manner stated.	owledge, ation and	death occurred at the t l/or investigation, in my	time, date and plac opinion, death occ	e, and due to the	e cause(s) and e, date and place	manner as ce, and due	stated. to the cause(s	5)
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'			30. Name and address of person will F. DELG 1700	no completed cause of death (Iter	m 23a) (Type, Print)	F NA	BAI	TIMO	NII	100	1221
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State Registrar F. DELGAMO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 1:48 AM FORD 2010 VIRGINIA MA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HUPKINS BAYUTEW HUSPITAL RALTIMORE 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. (Month, Day, Maryland 84 Yrs. Director 216-20-2105 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Baltimore 1 X Yes 2 ☐ No N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21224 USA 155 Grundy Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give White Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Housewife 10 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Margaret White Roland Rode Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8902 Kilkenny Circle, Nottingham, Maryland 21236 John H. Ford Jr. son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Date 1, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State June Cedar Hill Cemetery 4 Donation 5 Other (Specify) Brooklyn, Maryland 2010 Signature of Furieral Service Licensee 22 Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. rone 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, complications that caused the death bo not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Onset and Death Immediate Cause (Final disease or condition Physician/ Multi-system 1 week Medical resulting in death) Due to (or as a consequence of): Examiner Clostidium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of, physician and the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death for in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si irector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) æ examiner? n 24 hours after deatri. he Funeral Director: After this ce Other: 2 1 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural Pending work? 1 ☐ Yes 2 ☐ No. Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Homicide determined Medical 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I 29b. Signature and title of certifier MEDICAL 21224 Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSPITAL AGAO EASTERN ANE BALTINUNE MARTLAN JUHNS HUPKINS BAYVIEW

31. Date filed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May 27, 7:50 PM Josefa Flanigan 2010 /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Future Care North Point Dundalk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 7, 1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Yrs. 264-50-8087 81 Germany Director Usuel Residence of Decedent death with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "naturel", or flems 23a or 28a-f sho traumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🖫 No Funeral Director Maryland Baltimore Dundalk 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2011 Denbury Drive 21222 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Meritel Status permit. Pages 1 and 2 should be filed within 72 hours atter Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or its any follory or other traumatic event, the Medical Examina 1 ☐ Yes 2 X No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 years Housewife 2 years Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Anna Luken Ludwig Ferending 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2011 Denbury Drive, Dundalk, Maryland 21222 Lester Flanigan Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 2, Sacred Heart Of Jesus Cemetery Dundalk, Maryland 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Cardiac Archythmias Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Tes 2 No 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No ٩ filled in by the funeral 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 112/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the To the 29d. Date signed (Month, Day, Year) 05-28-2010 29b. Signature and title of certifier MD 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 709. BASTERN BLVD WASBEM. MD-21221 MALIKA 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture

DHMH 16 Rev 6/95

State

Registrar

JUN 02

Division of Vital Records, P.O. Box 68760.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 30 David Marshall Fredenburg 4:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harmony Hall Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F APR 16, 1932 Months Hours North Dakota 263-44-1711 Director Usual Residence of Decedent 28a-f show 10a State 10b. County shoun مدر المراجعة على المواجعة المراجعة c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Columbia 1 Yes 2 X No Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6336 Cedar Lane 21044 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ▼ Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. 3 X Widowed 4 Divorced Completed White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done of the contract of the during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Information Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Ralph Fredenburg Mary Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 17 Hilton Court Debra M. Kapsak, daughter Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once, ò Metro Crematory, Inc. 06/01/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road BAltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events g physician and as the burial-transit Exami Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 Yes 2 No g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? perform 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Muse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 2010 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso 103 334 Ceden (921. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Casey Michael Fitzgibbon

Plea

se Type or Print in Black Indelible Ink. Ensure All Copies Are Legible	16966
State of Maryland / Department of Health and Mental Hygiene	, 0 0 0 0

		1- For State Registrar			Certific	ate of	Death	7				Reg. No.			
Physicia		Decedent's Name (First, Middle)	le,Last)							2	. Date of De	ath	Van		3. Time of Death
Medical Exami	ner	Casey Michael	Fitzgib	bon							Month May 26,	Day 2010	Year		0830 hrs
		4a. Facility Name (if not institution Baltimore Washington	_			4	4b. City, Town, or Location of Death Glen Burnie						County o		
Funeral	-	5. Social Security Number	6. Sex	7. Age (Ir	n yrs. last bir	thday)	If Under	r 1 Year	If Under	24Hrs.	8. Date of E	sirth (MM/C	DD/YYYY)		place (State or Foreign
Director		207–66–2050	1XM 2 F	3	1	Yrs.	Months	Days	Hours	Min.	04/1	1/197	9	Penr	nsylvania
Š.	- }	Usual Residence of Decedent 10a. State 10b. County		110	c. City, Town	or Locatio	n .								10d. Inside City Limits
aryland 8a-f show any at once.	ō	Maryland Anne	Arundel		Severn										1 X Yes 2 No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene tent and Mental Hygiene tent 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Mede. I Examiner must be notified at once.	Director	10e. Street and Number 1754 Sea Pine C	Circle				10f. Zip (2114					10g. Citize Unit	en of Whated S		-
n with a ms 23s	ल	11. Marital Status	A a .d	ecedent Eve Forces?	er in U.S.		Deceden s, specify				cify Yes or N	10-	14. Race · White		an Indian, Black,
ter deatl ", or ite	Funer	23	arried 1 Yes	2	No 2-2001		Yes 2	_		CONTO	oan, oto.,		Specify:		-e
5-0036 led within 72 hours after tygiene other than "natural", the Medir I Examiner	ed by	15. Decedent's Education (Spe	or Dates: ecify only highest gr	1771		Decedent' during mo	s Usual C	occupatio	n (Give ki				ind of Bus		
36 in 72 h	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)	Tn	forma						Fur	nitu	re F	Retail
1 with giene	E O	17. Father's Name (First, Middle,	Last)		1 11.	ITOTIII	a CLIOI				irst, Middle,				
21215-0036 and be filed within 7 Mental Hygiene marked other than e event, the Media.	Be	Gerald F. Fitz	gibbon					S	arah	Α.	Shere	r			
e, MD 21215-00; 1 and 2 should be filted with Health and Mental Hygiene item 27 is marked other tr rraumatic event, the Mer	2	19a. Informant's Name/Relations Gerald F. Fitzo		Fathe:							al Route Nu th Ve	rsail	les,	PA	15137
2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -		20a. Method of Disposition 1 Burial 2 Cremation	n 3 🔽 Removal	from State		tory or othe	er place)		- 1		Date	1			own, State
Baltimore, permit. Pages 1 at Department of He Important: If ite	ļ	4 Donation 5 Other Se	pecify:		Kutch			-	l.						sport, PA Homes PA
Bal permi Depa Impo injur	4	J. Signature of Pulleral Get vice	Mulus												pland 21231
Physician		23a. Part I. Enter the disease, or failure. List only one cause		caused the	death. Do n	ot enter the	e mode of	dying, su	ich as car	rdiac or r	espiratory a	rest, shoc	ck, or hea	rt	Approximate Interval Between Onset and
Medical Examiner	İ	Immediate Cause (Final disease or condition resulting in death)	a. Contact C			Head									Death
	اءِ	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a conseque	ence of).				_						
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated													<u></u>
760, icate be executed physician and the burial - transit		events resulting in death) Last	d	a conseque	ence or).										
e exection a	dica	UNPENDED	AMENDED)											
760, ficate by g physic t the bur	§	IF FEMALE: 23b. Was decedent pregnant in the			of pregnancy				1				. Date of o		
30x 687 death certifing a attending I for use as t	Physician/Medical	past 12 months?	I LIVE	birth gnant at time	e of death	Feta	aldeath er (<i>Speci</i> i		Ectopic p	pregnanc	У	'	Month	Da	y Year
Box 68 e death certification the attending ed for use as	ysi	1 Yes 2 No 9 Uni	known g Unk				er (opcon								
that the	by P	Part II. Other significant condit	tions contributing	to death bu	t not resultin	g in the un	derlying o	cause giv	en in Part	t I.			_		e cause of death?
ords, F w requires s been sign should be											24a. Was				opsy findings available
COFC law re has be	Completed			<u> </u>							auto perf	psy orm <u>ed</u> ?	pr de	ior to co	mpletion of cause of
tal Rec		25. Was case referred to medica					26	S Place o	f Death (0	Shook on		2 No	1	✓ Yes	2 No
/ital F sician: nis certifi director,	Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 🗸 ER/O	utpatient		10			fome 5	Residen	ice 6	Other:	
ding Phy.	n: ٦	27. Manner of Death	28a. Da	te of Injury th, Day,Year) D:	28b.	Time of Inj	· 1	_	at Work?	ا ا	Bd. Describe		y occurre	d	
ttendi death.	atio	1 Natural 5 Pend 2 Accident Inves	stigation May 2	6, 2010	070	JND: 7 hrs			s 2 🗸 N	V0					
Division of Vital Records, P.O. pital or Attending Physician: The law requires that it ours after death. reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deta	Certification:		d not be		- At home, fa		, factory, o	office buil	lding, etc.		3f. Location or Town, 40 Disney	State)			al Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - mansi		202 Certifier	hysician: To the b	est of my kn	owledge, de	ath occurre				e, and du	ie to the cau	ise(s) and	manner	as stated	1.
Tot with: Tot	Medical	29b. Signature and title of certifie	and manner	stated.		3		License r				_			h, Day, Year)
		and.						O.C.M	.E.			Мау	27, 201	10	
		30. Name and address of person Ana Rubio MD. Ass	who completed ca			Penn St	reet. Ba	altimore	e, MD 2	21201		•			
St	ate	31. Date filed (Month, Day, Year)		Registrar's S					_,						
Regist	rar	IIIII O O '	2010 /2	accent	A.	back	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		ertificate o	f Death		Re	g. No.	
Physici Medical Exami		Decedent's Name (First, Middle, L. Debase		0:11			2. Date of Death Month	Day Year	3. Time of Death 1153 hrs
nedicai Exam	iici	Debra 4a. Facility Name (if not institution, g		Gill	4b. City, Town,	or Location of Dea	May 29, 20	4c. County of De	
		Baltimore Washington M	edical Center		Glen Burn	ie		Anne Aruno	iel
Funeral				s. last birthday)	If Under 1 Ye	ear If Under 24H		Fo	Birthplace (State or reign
Director			M 2XF 52	Yr		1,0013	Nov. 3	3,1957	Country) MD
any		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Loca	tion				10d. Inside City Limits
* .	_	MD Anne	e Arundel		Pa	sadena			1 Yes 2 XXNo
Maryland 28a-f show	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Whet C	ountry?
with the Maryland ns 23a or 28a-f sho be notified at once		8004 Corkberry	Lane Apt. 3	17		21122		United	States
th with	Funeral	11. Marital Status 1 Never Married 2 XXMarrie	12. Was Decedent Ever in Armed Forces?			Hispanic Origin? (S an, Mexican, Puert	Specify Yes or No- o Rican, etc.)	14. Race - An White, etc	nerican Indian, Black, c.
ter dea			1 Yes 2 No	1	Yes 2K N	lo specify:		Specify:	White
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	d by	15. Decedent's Education (Specify	or Dates:	16a. Decede	nt's Usual Occup	ation (Give kind of		16b. Kind of Busine	
6 172 hc an "na cal Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			fe. DO NOT use re	tirea)	O II-	
withir with the result of the	E	10 Years 17. Father's Name (First, Middle, La	o+\	Hous	ewife	18 Mothor's Nam	ne (First, Middle, M	Own Ho	ome
21215-00: ould be filed with 1 Mental Hygiene 5 marked other to ic event, the Men	BeC	Royal H. Laws	•			10.Motrior 5 Harr	Wanda S.		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	P	19a. Informant's Name/Relationship						per, City or Town, St	
M 2 alth		Mr. Edward J.		·	Communi			Park, MD	21146
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other trau		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	b. Place of Dispo Ciematory or of Lawn	ther place)	· .	Date	Baltimor	·
Baltimo permit. Page Department of Important: injury or otl		4 Donation 5 Other Speci	fy:	len/Have	n Cemet	,	3/2010		
Balt permit. Departe Import		21 Signature in Funeral Survice Lio	V- Kull	/ 2	uda-Ruc 7022 Wie	k Funera	l Home of Jundalk,	Dundalk Marvland	Inc. 21222
Physician		23a. Part I. Enter the disease, or con		ath. Do not enter	the mode of dying	g, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
™edical Examiner	tailure. List only one cause on each line. Immediate Cause (Final disease a, Sharp Force Injuries								Death
		or condition resulting in death)	Due to (or as a consequence	e of):					
	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):					
	Examiner	cause. Enter Underlying Cause (Liseass or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):					
executed an and al - transit			d						
	Medical	UNPENDED	AMENDED						
8760, ificate be ag physicials the buria		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pro		etal death 3	Ectopic pregn	ancv	23d. Date of deliver Month	very Day Year
Box 68's death certification attending	sician/	past 12 months? 1 Yes 2 No 9 V Unknow	4 Pregnant at time of	doath -	ther (Specify)				
). Bo: t the deat by the att	Phy	Part II. Other significant conditions	O DIMINUTI	t regulting in the	underlying cause	given in Part I	23e Did tob	acco use contribute	to the cause of death?
F. P.O. ires that the signed by	ā	Ture ii. Out of Significant Conditions	, contributing to death put no	cresulting in the	andonying cadac	given in raici.			robably 4 Unknown
ds, require	ompleted						24a. Was ar		autopsy findings available
e law e has be	립						autops perform 1 ✓ Yes 2	ned? death	
Ital Reco ician: The law certificate has	ပ္ပိ	25. Was case referred to medical			26.Plac	ce of Death (Check		No1 ✓	Yes 2 No
of Vital Records, or Physician: The law requir when this certificate has been some and inector, page 2 should	O.	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	✓ ER/Outpatien	3 DOA	Other Nursi	ng Home 5 R	tesidence 6 0t	her:
n of Jing Phy. L. After t	Ë	27. Manner of Death 1 Natural 5 Deading	28a. Date of Injury (Month, Day Year) May 29, 2010	28b. Time of 0244 hrs	· · · _ ·	ury at Work?	28d. Describe ho Subject was	ow injury occurred stabbed	
Division tal or Attendi rs after death. al Director: A	catic	2 Accident 5 Pending Investiga				Yes 2 ✓ No	206 Lacation (Ct	and and Number of	Rural Route Number, City
Divi pital or ours after eral Dir	ertification:	3 Suicide 6 Could not determine 4 ✔ Homicide	ot be	riome, raim, sire	et, factory, office	building, etc.	or Town, Sta		
Hospi 24 hou Funer tely fil	ပ	29a. Certifier 1 Certifying Physi	cian: To the best of my knowle				d due to the cause	(s) and manner as s	tated.
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examin	er: On the basis of examination and manner stated	and/or investiga					
E > E 0	Σ	29b. Signature and title of certifier	1/ 1			nse number	1	29d. Date signed (i	Month, Day, Year)
		Tunelly outh	iu, mo	00.)	0.0	.M.E. 		May 30, 2010	
7		30. Name and address of person who Pamela E. Southall, MD	completed cause of death (Ite Assistant Medical Ex		1 Penn Stree	et, Baltimore,	MD 21201		
S	ate	31. Date filed (Month, Day, Year) 2			4				
Regist	rar	JUNU2	2014 Jeneus	1 1	adel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 16^{Day}-Anthony Charles Gilchrist 2010 7:16 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗌 Months Hours 05-10-1970 577-98-4876 **Director** 40 Wash., Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director MD Clinton Prince Georges 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7219 Earl Drive 20747 U.S. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Carpentry 12th Grade any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Gilchrist Audrey Yarborough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alita Gilchrist - Wife 7219 Earl Dr. / Clinton, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 05-27-2010 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Murray & Tellington Funeral Home/4804 Georgia Ave, NW/Wash., DC 20011 23a. Part 🗸 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ astroint disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to or as a consequence of if any, leading to immedi-cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filied in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Yes 2 No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ver 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Failure autopsy performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 W No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) 32. Registra s Signa State IUN 0 2 2010 Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mayort 31, 2010 Joseph James 6:00 Gomeringer, Sr. Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore 830 Dorsey Avenue Essex 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 XM 2 - F 11/29/1926 **Director** 215-22-0342 83 Pennsvlvania or 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he motified of 10a, State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 U.S.A. 830 Dorsey Avenue 12. Was Decedent Ever in U.S.
Armed Forces?
12 Yes 2 No
15 Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1945 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1946 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick James Gomeringer Christine Scheppers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 830 Dorsey Avenue, Baltimore, Maryland 21221 Norma Gomeringer (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Holly Hill Mem. Gard: 06/05/2010 4 Donation 5 Other (Specify) Baltimore, Maryland Signeth of Faneral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final di ease or condition Onset and Death Physician/ CANC 00 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this contract. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No Were autopsy findings available prior to completion of cause of 24a. Was an To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2 s autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Tes 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 06-01-2010 30. Name and address of son who completed cause of death (Item 23a) (Type, Print) GAMO 31. Date filed Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ ROBERT HENRY GREENSFELDER 04:50 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE CITY (tospital of Raltimore Saltimore 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1.XM 2□F Days Hours May 24, 1927 220-20-9018 Months 83 Maryland Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1XXX Yes 2 □ No Baltimore City Maryland Baltimore City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21206 USA 4706 Schley Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2X Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced WWll 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Kuoun as: 2 yrs. Accounting Industry Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H Elisabeth Schultheiss William Greensfelder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4706 Schley Avenue Baltimore, Md. 21206 Anna Marie Greensfelder (Wife) Baltimore, FIRM 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State 5~29~2010 Immanuel Luth.Ch.Cem. Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee ²² Name and Address of Facility I Home 7401 Belair Rd. Baltimore, E. F. Lassel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Mulfi-Syskin organ disease or condition resulting in death) days Medical Due to (or as a consequence of): Examiner crdio my orath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Die to (or as a consequence of): Renal Failure attending physician and if for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death signed by the at d be detached fo g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ arbery disease, It y pertension, Congestive Division of Vital Records, 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed To the Hospital or Attending Physician; The law require within 24 hours after death.

To the Funeral Director; After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Renogenic anemia autopsy performed? Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2. No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 L 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) May 26, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nea HOSDU Caltimore (nac 31. Date filed (Month, Day, Year) 32. Re

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DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b,c per fh g904 6-4-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 3:37 PM 4 1BSON 2010 LARY /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner RANDALLSTOWN BALTIMORE NORTHWEST HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 ▼F 216-28-2449 MD Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Exartment quat be notified at 1 □Yes 2 No MD Baltimore Windsor Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21244 3121 Gartside Avenue 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black Specify: \$ 3 Widowed 4 □ Divorced 'natural", Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Private Dut Domestic permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiens important: if item 27 is marked other the any injury or other traumatic event, II along. 2th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wallace Snell Bessie Lwing ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Lame/Relationship (Type. Print) 4524 Manyknoll Road Pikesville MD 21208 /Daughter Youna Keth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Windsor Mill Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Date 2010 Ballimore, MD King Memorial Pk. 22. Name and Address of Facility Vallahn C. Greene Funeral Sentes 21. Signature of Funeral Service Licensee Road Pandallstown ND 21133 Vau -iberty Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): **Examiner** OBSTRUCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the as t attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fet*a*l death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examination On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the cau 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu D0060293 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COURT ROAD RANDAUSTOWN 5401 ALMED. OLD MD MURNZA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gaydos Donald A M May 2010 7:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Ivy Hall Nursing Center Middle River Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 7, 1932 **Funeral** 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Hours Maryland 219-28-4410 Director 78 Usual Residence of Decedent or 28a-f show notified at 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 ☐ Yes 2 ☐MNo 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 10 S. Stuart Street 21221 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important I fitem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 years Barber Hair Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Gaydos Anna Lapetina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madeline R. Gaydos wife 10 S. Stuart Street, Essex, Maryland 20a. Method of Disposition June 1, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Bayview Crematory 4 Donation 5 Other (Specify) Baltimore, Maryland 2010 ign vure of Fun ral Service License Connelly Funeral Home Of Dundalk, P.A. moni 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Rumma disease or condition m out Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or initiary that initiated events the attending physician and thed for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Certificate: To 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 00 H35593 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battmore MD 2/22 JOHN 1124 0/ 31. Date filed (Month, Day, Year) legistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Year Elroy R. Gainous 14:19 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 13, 1943 6. Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours 212-42-0312 Director 67 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Baltimore Catonsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1605 Collinsway Road 21228 **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married <u>۾</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver should be filed with and Mental Hygien fis marked other th Local Hauling other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pierce Gainous Katharyn Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Desiree R. Gainous, wife 2018 Braddish Avenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 05/31/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ACUTE INFARCNON disease or condition one week Medical resulting in death) Examiner THEROSLERONC CORDNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-1 Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 L 9 Unknown 2 No 9 Unknown P.O. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAC Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown RESPIRATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 s performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 24 hours after death. Funeral Director: Al 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2. only one) 29b. Signature and title of ce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO: NU MEMORIAL HOSPITAL BALTIMORE MD

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May ^{Day} 2010 Year Viola Theresa Grammer 25 5:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 561 Sarah Avenue Linthicum Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Months Director 213-14-5479 89 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel MD Linthicum 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 561 Sarah Avenue 21090 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ≥ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: USA Completed 3 X Widowed 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Food Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dominick Cantore Jennie Landolfa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry L. Berry / Daughter 561 Sarah Avenue, Linthicum, Maryland 21090 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) Entombment Loudon Park 5/28/2010 Baltimore, Maryland 21 Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial disease or condition Medical resulting in death) Due to (or s a consequence of) Examiner DEVACASION Sequentially list conditions if any, leading to immediate Examine cause. Enter Underlying Dementio Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Advanced Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ Day Pregnant at time of death the 'ed ed by t signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: After moleted filled in by the fun work 1 \square Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my college death. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. 29b. Signature and title of certifier Chandellur May, 26, 2010 D0052490 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Hanovust. Baltimore mp 21228 Khandelway ND 31. Date filed (Month, Day, Year) 32. Registra State Registrar

DHMH 17 Rev 7/2009

10-04098 Timothy Gaskins	, Jr			ble.	5975
		1- For State Certificate of Death Registrar	Reg.	No.	
Physicia Medical Examir		1. Decedent a Name (1 iia), Middle, Laasty	2. Date of Death Month E May 29, 201	Day Year	3. Time of Death 1708 hrs
Wedical Examin	ICI	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Way 29, 20	4c. County of Death	
		Johns Hopkins Hospital Baltimore		<u> </u>	
Funeral Director		5. Social Security Number 6. Sex 1 Nage (In yrs. last birthday) 1 Nonths Days Hours Min. 1 Nonths Days Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. Birth Foreign Cou	
and I show any <u>nce.</u>	or	10a, State MD 10b. County 10c. City, Town or Location Rallimore			10d, Inside City Limits 1 Yes 2 No
r death with the Maryland or items 23a or 28a-f show must be notified at once.	al Director	10e. Street and Number 3544 LYNdo e Avenue 10f. Zip Code 21213 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe		Citizen of What Coun	
ifter death wi I", or items	y Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Pales: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, Sieve Year 1 Yes 2 No specify: 1 Yes 2 No specify:		White, etc. Specify:	lack
15-0036 filed within 72 hours after death with the Maryland 1 Hygiene. ed other than "natural", or items 23a or 28a-f she t, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) The secondary (0-12) College (1-4 or 5+)	ed)	Riverview N	4
O 3 2 2 5	Be	17. Father's Name (First, Middle, Last) Timothy Lee Gaskins St. 18. Mother's Name (Danyel	(First, Middle, Ma	eiden Surname)	
MD nd 2 sho alth and traumati	ျှ	19a. Informant's Nam /Relationship (Type, Print) 19b. Mailing Address (Street and Numb r or Ru 1200 Hands Worth 20a. Metrod of Disposition (Name of cemetery,	nal Route Number	er, City or Town, State, 20c. Location - City or	Zip Code) Yd. 21221 Town, State
Baltimore, permit Pages I a Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: 1. Signature of Funeral Stryice Hospinger 22. Name and Address of Facility	4 2010	Batimore	Maryland
Balti permit. Departu Imports	-	Vaughn C. Greene 1.5	े त्र	attimore,	Md. 21217
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	respiratory arres	i, shock, or heart	Approximate Interva Between Onset and Death
A. A.		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
P is	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
xecuted and rand	ia E	d.			
6 be es	ēģ	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ncy		ay Year
O. Bonat the de etached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to t	
b, P.O. ires that the signed by 1 be detach	d by		1 Yes	2 No 3 Prob	ably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requir rs after death. "al Director: After this certificate has been siled in by the funeral director, page 2 should	Completed		24a. Was an autopsy perform	prior to coned? death?	topsy findings available completion of cause of
tal F cian: certific ector, p	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; 4 Nursing			
of Vii ng Physia After this	ဥ	27 Manner of Death 28a Date of Injury 28b, Time of Injury 28c, Injury at Work?	28d. Describe ho	esidence 6 Other	
ivision of volutions of a Attending Phafter death. Director: After to the funeral	Certification:	1 Natural 5 Pending Accident Investigation May 29, 2010 0028 hrs 1 Yes 2 No	Subject shot		- I Pooks Northean City
Divis al or A s after al Dire	Ţį	3 Suicide 6 Could not be determined (Specify) Sidowalk		reet and Number or Ru lite) hent Street, Baltimor	
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Medical Ce	4 Momicide (Specify) Sidewalk [22] 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	due to the cause((s) and manner as state	ed
£ \$ £ 8	Me	29b. Signeture and title of certifier 29c. License number O.C.M.E.		29d. Date signed <i>(Mor</i> May 30, 2010	nth, Day, Year)
		30. Name and address of person who completed cause of death (item 23a)		-	
	ate	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212 31. Date filed (Month, Day, Year) 32. Registrar's Signature	201		
		66891 @ @ @@@@			

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per Fh G904 6/29/10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 8 55 PM Talmadge Devere Glenn 2010 Medical bu 30 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltomore n/a HES PITAL of Bathmers Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Birthpia-Country) MD **Funeral** 1 XM 2 F Months Days Hours Min. 68 12/23/1941 Director Usual Residence of Decedent of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marks awant the Medical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2534 Druid Park Drive 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces?
1 ☐ Yes 2 XNo Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specif Black Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natum any injury or other traumatic event, the Medical any injury or other traumatic Glehn, Talmadge 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Construction Master Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clemit Odell Glenn Mattie May Goins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2534 Druid Park Dr Baltimore, MD 21215 Troy Glenn-Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) ☐ Burial 2 Cremation 3 ☐ Removal from State 6.7.2010 Baltimore Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) . Si ture of Funeral John L. Williams Funeral Directors, P.A. Þ 4517 Park Hots Ave Baltimore, MD 21215 23a. F 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Arche myscardy disease or condition resulting in death) Lyling Medical Due to (or as a conse ru-nce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 5 Other (specify) Month Year ☐ Pregnam
☐ Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy page 2 performed 2 No 1 Yes 25. Was case referred to medical examiner? Be (uneral director. 26. Place of Death (Check only one) Hospital: Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide death Investigation arter death Director: / the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Within 2 To the P only one) 29b. Signature nd title of certifie 29c. License number 29d. Date signed (Month. Day, Year) RES. OOM May 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 2401 W. Belvedore Ave Baltimore, MD 7215 GAUVIN Jean 31. Date filed (Month, Day, Year) 32, Regis rar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) 8:16 P M 2010 27 Physician/ May Huskamp Jeffrey Craig Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Silver Spring 305 Reserve Gate Terrace 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Oct 17, 1949 5. Social Security Number Kentucky Months **Funeral** 1 🔀 M 2 🗆 F 60 402-62-7996 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or 28a-f show 10a. State the Medical Examiner must be notified at Director the Maryland 1 🗌 Yes 2 🔀 No Silver Spring Maryland Montgomer 10g. Citizen of What Country? 10e. Street and Number United States permit. Page 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a o any injury or other traumatic event, the Medical Examina. Funeral 20905 305 Reserve Gate Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 M Married þ White Specify: 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Computer Technology Elementary/Seconday (0-12) Information Officer 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Strunk Maxine Eleanor ည Raymond Huskamp Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20905 19a. Informant's Name/Relationship (Type, Print) 305 Reserve Gate Terrace Silver Spring, Maryland Sandra W. Huskamp/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Woodbine, Maryland Final Journey Crematory 5/29/2010 4 ☐ Donation 5 ☐ Other (Specify) Going Thomes Cremation Service P.O. Box 784 21. Signature of Funeral Service Lic Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Thomas M00957 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death years Immediate Cause (Final disease or condition Metastatic Prostate Cancer Physician/ Due to (or as a consequence of) Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year Month in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown à Venous Thrombosis Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 26. Place of Death (Check only one) Hospine.
24 hours after death.
e Funeral Director: After this certifica 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 2 XNo မြ 1 Yes 28c. Injury at 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending 1 X Natural Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide
4 Homicide completed filled in by determined Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one 3 29d. Date signed (Month, Day, Year)

2730 University Blvd. #400 Wheaton, Maryland 20902 M.D. Linda M. Burrell, 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Signature and title of certifier

ndi

D35996

2010

May 28,

		•	For State Of Maryl State Registrar	•	tificate of De		, 0	епе eg. No.		
Physician/ Medical			1. Decedent's Name (First, Middle, Last) To HN	1-	HOWARD		2. Date of Death Month		3. Time of Death / 1230 P M	
Examiner			4a. Facility Name (if not institution, give street and number) NORTUWEST HOSPIML	4b. City, Town, or Location of Death RANDALLS 70WN			4c. County of Death BALTIME			
	Funeral Director	uneral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda				f Under 24 Hrs. Hours Min.		place (State or Foreign		
	laryland 3a-f show iffied at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. MD Baltimore 10c.	City, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 🛂 No	
	vith the N 23a or 28 st be not	eral Dir	10e. Street and Number 1923 Featherbed Lane		10f. Zip Code 21207			10g. Citizen of What Country? USA		
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Married Forces? 1 Married Forces? 1 Married Forces? 1 Married Forces? 1 Married Forces? 1 Married Forces? 1 Married Forces? 1 Married Forces? 1 Married Forces?	1	Vas Decedent of Hisp Yes, specify Cuban,		ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,		
Maryland 21215-0036	hin 72 hou ne. than "natu ie Medi al	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	16a. Deced (Give k life, D0	cedent's Usual Occupation ve kind of work done during most of working . DO NOT use retired)			16b. Kind of Business Industry		
and 2	be filed wit ental Hygie ked other c event, th	To Be C	10 17. Father's Name (First, Middle, Last) William W. Howard	_ Ko	oute Salesman 18. Mother's Name (First, Middle, M			Dairy Products Maiden Surname)		
Mary	and 2 should Health and Me tem 27 is marl other traumati		19a. Informant's Name/Relationship (Type, Print) Grace C. Howard Wife			l Number or Rura	al Route Number, C	City or Town, State, Zip o	Code)	
Baltimore,	Page 1 and nent of Hes ant: If item iry or othe		1 Pennial 2 Cramation 3 Pennaval from State	b. Place of Dispos cemetery, crem	sition (Name of patory or other place) Cemetery	6/2/2		20c. Location - City or To		
Balti	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Mi Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville, MD 2							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A PARCTIC Due to (or as a consequence of): Sequentially list conditions.							or respiratory arres	t,	Approximate Interval Between Onset and Death	
1760	icate be executed physician and is the burial-transit	ledical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a constitution of the constitutio	sequende vi):	ZIERY D	ISEASE				
P.O. Box 687	Io the Hospital of Attending Priysician: The law requires that the death certifica within 24 hours after death. To the Teuhours after death. To the Teuhoral Director After this certificate has been signed by the attending placempleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the complete of the complete	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv	rery Day Year	
ls, P.O	ures that the start of the signed by the sig		Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause given	in Part I.		acco use contribute to to		
Division of Vital Records,	ne law require tte has been si page 2 should b	omplet	ACUTE RENAL FAILURE CHOLECYSTITIS				24a. Was an autopsy perform	prior to co	psy findings available ompletion of cause of	
ital	certifica	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Other	of Death (Check	k only one)			
n of V	iding Physith. After this funeral di	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28b. Time of	ent 3 L J DOA 4 Nursing Home 5 L R			Residence 6 🗆 Other (Specify) be how injury occurred		
Divisio	tal or Atterns after des al Directored in by the	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe					(Street and Number or Rural Route Number, wn, State)		
- 1	to the floopstal or Attending Prystotan: The is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	(Check 2 Medical Examiner: On the basis of examina only one) 3 Confifting Attrice Practioner: To the best of	ation and/or investi	n occured at the time, date and place, and due to the stigation, in my opinion, death occurred at the time, dat , death occurred at the time, date and place, and due to 29c. License number			ite and place, and due to the cause(s) and manner stated.		
	o o o with o		29b. Signar fe and title of dertiff							
	AT		30. Name and address of person who completed cause of death (I 5401 OLD COURT ROAD.		rint)	1 40	MD 2	21133		
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Sig			-		192		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 #9 per FH G904 6/11/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 6.30 05 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Health Corre altimore Homewood Saltimor 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex M 2□ F 8. Date of Birth (Month, Day, 5. Social Security Number Months -48-0717 Usual Residence of Decedent 10c_City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Nes 2 No Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0000 0/ by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No 1 □Yes 2 🗷 No If Yes, Give Year or Dates: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospitality Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank B. Harper Katharine Hughes ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Harper/Brother 817 Park Ave. Apt. 3, Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06.03.10 Our Lady of The 4 ☐ Donation 5 ☐ Other (Specify) Millersville, MD Fields Cem. 22. Name and Address of 21. Signature of Funeral Service Licensee CAFA/Stephen D. Lohrmann, PA Green Pastures Dr. BAlto. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

that the death certificate be executed and burial-tra Division of Vital Records, P.O. Box 68760 attending physician for use as the buria the signed by I The law requires icate has been si certificate : After this certification, I or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu hours after death. To the Hospital within 24

Funeral

Director

28a-f show

r than "natural", or items 23a or 28a-f shov

is marked other than

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. M.

Physician /Medical

Examiner

within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar 29a. Certifier

one)

(Check only

29b. Signature and title of certifier

881 31. Date filed (Month, Day, Year)

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 4:10 PM may Medical Ravmond 010 Havsbert 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death <u>Union Memorial</u> Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Min. 1 🔀 M 2 🗆 F Yrs Director 90 272-14-4634 OH Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location must be notified at 10d. Inside City Limits Funeral Director 1 X Yes 2 No Baltimore NA 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3300 Hillen Road 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by "natural", or 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours afterment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give 3 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygier 12th grade 4yrs+ Business Manager Forum Caterers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ <u>William Haysbert</u> Emma Walton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S E. Haysbert-Wife Hillen Road, Baltimore, Md 21218 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl once. Date 20c. Location - City or Town, State ☐ Burial 2x Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) On-Site 5/27/2010 Baltimore, 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Ave. Baltimore, Md Part 1. Enter the disease, or complication. That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease of injury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last physician the burial Be Completed by Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No the detached a 🗌 Unknown g Unknown P.0. certificate has been signed by irector, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical **Division of Vital** funeral director. 26. Place of Death (Check only one) Hospital 2 M No Other: ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 31. Date filed (Month, Day, Year) 32. Regis ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

East

29b. Signature and title of certifier

H0061180

Bulhnux, Muryland

Partiway

Jamie HilTon-Bey 10-03852 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month **Medical Examiner** 0125 hrs amie May 20, 2010 4a. Facility Name (if not institution, give street and number) b. City, Town, or Location of Death c. County of Death Sinai Hospital **Baltimore** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign 219-86-0761 Months Days Hours Director 1X M 2 F 35 30,197 Country) June MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore X Yes 2 No with the Maryland Director 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 3728 St. Margaret St. 21225 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 X No Yes Specify: Black Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
Tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. If Yes, Give Year 4 Divorced 1 Yes 2 X No specify: ₹ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specity only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Self Employed Real Estate 10th N/A 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Sumame) Eugene Hilton-Bey Darlene McKennev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene McKenney/Mother 163 Navajo Trail Goulesboro, PA 18424 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) 5/27/10 Ardent Crematory Hanover, MD Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility} Beverly D. Cromartie F/S **2**700 Edmondson Ave. Balto., MD 21223 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a. Multiple Gunshot Wounds Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause Disease or injury macinitiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical physician a UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the use as t Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) for 1 Yes 2 No 9 Unknown signed by the a 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ę 1 Yes 2 No 3 Probably 4 Unknown Completed s certificate has been rector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? Yes 2 No death? 1 🗸 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director, 25 Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 V ER/Outpatient 3 TDOA 1 V Yes 2 No 28a. Date of Injury 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: May 20, 2010 Subject was shot 1 Natural 0048 hrs 5 Pending 1 Yes 2 ✓ No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 4200 Elderon Avenue, Baltimore, Md. determined (Specify) Inside van 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 20, 2010 ss of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

Pamela E. Southall, MD

31. Date filed (Month, Day, Year)

Bankle

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Regir frar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 8:00 **Medical** J. May <u>Hayman</u> 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sacred Heart Home Prince Georges Hyattsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** May 26, 1918 1 □ M 2 🖾 F Months Hours Min New York 91 Director 264-58-6409 Usual Residence of Decedent or 28a-f shown notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Prince Georges MD Hyattsville 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 5805 Queens Chapel Rd 20782 USA Was Deceuc... Armed Forces? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify "natural", 3 ₭ Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 72 it of Health and Mental Hygiene.

If item 27 is marked other than "roor other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edmond Jaslofsky Josephine Colon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Hayman/daughter 4514 Connecticut Ave NW Apt 206 Washington, DC 20008 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o ☐ Burlal 2 「Cremation 3 ☐ Removal from State Metropolitan Crematory 5/29/2010 Alexandria, VA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Marshalls Funeral Home M00977 4217 9th St NW Washington DC 20011 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any Ladin. Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Poor intake, adult failure to thrive 24a. Was an performed? Yes 2 1 No Hypertension 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital Other: 2X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State

Medical

29a. Certifier

29b. Signature and title of certifier

Christ 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

29c. License number

D43121

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

5/27/2010

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Chowdhury, MD 15216 Dino Dr Burtonsville, MD 20866

31. Date filed (Month

determined

egistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 3 per doc g904 6-11-10 vt
State of Maryland Department of Health and Mental Hygione

			For State of Maryland / De State of Maryland / De Registrar	partment o <i>ertificate d</i>		, ,	iene eg. No Dan	16983	
	Dhysisi	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death	h	3. Time of Death	
	Physici /Medio	al	Mary Elizabeth Hillman	_	May	21 2010 9:50 a			
	Examin	er	4a. Facility Name (If not institution, give street and number) Crescent Cities Center	4b. City, Tow	n, or Location of Deat ale	h	4c. County of Death Prince Georges		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		ear If Under 24 Hrs	8. Date of Birth		hplace (State or Foreign untry)	
	Director		577-26-7199 1 M 2/C F 89 Yrs	. Worth's Da	ys Hours Min.	8. Date of Birth (Month, Day, 02/19/	/1921 Arri	ngton, VA	
	yland now		10a. State 10b. County 10c. City, Town o	Location				10d. Inside City Limits	
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	a or 2	Dire	10e. Street and Number 3808 17th St NE	10f. Zip Cod	de 20018	10	ng. Citizen of What Co USA	untry?	
	ns 23	Funeral				Specify Yes or No-	14. Race - Ame	rican Indian	
5-0036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, it f'edice! Everifizer must be notified at	Ş	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, specify (1 ☐ Yes 2 🖾	of Hispanic Orlgin? (S Zuban, Mexican, Puerl No <i>Specify:</i>	to Rican, etc.)	Black, White		
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yiand	2 should be fin and Mental Fis marked of raumatic even	၉	John Doswell			e Allen			
e, mar	and 2 sh lealth and m 27 is n her traun		Alvin Doswell Hillman/son 500	8 Henders	son Rd Te	mple Hill	City or Town, State, Z		
Dallimore Dermit, Pages 1: Department of He Important: If iten	permit. Pages 1 and 2 should b Department of Health and Ment Important: If item 27 is marked any Injury or other traumatic e once.		1X Burial 2 ☐ Cremation 3 ☐ Removal from State	sposition (Name of rematory or other Memoria	place) ¦		Suitland M		
Dall	permit. Depart Import any Inj once.		21. Signature of Funeral Service Licensee		Idress of Facility Mar		uneral Hom DC 20011	le	
			23a. Par(1) Enler the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of	dying, such as cardiad	or respiratory arre	st,	Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease a. Coronary Artery Disease						
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ָה ה	s that t ned by e detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause	given in Part I.	23e. Did toba	acco use contribute to	the cause of death?	
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י שבי	To the flospital or Attending Physician: The law requires that the of within 24 hours atter death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed				24a. Was an autopsy perform 1 □ Yes 2	prior to death?	topsy findings available completion of cause of	
ב ב	ician; certific ector,	Be	25. Was case referred to medical examiner? Hospital: Ho			th (Check only one			
5	g Phys er this eral dii	<u>ا ي</u>	27. Manner of Death 28a. Date of Injury 28b. Time	IEIIL 3 LI DON			nce 6 Other (Spec	cify)	
5	ath. ath. ir: Afte	atio	1 🖄 Natural 5 □ Pending (Month, Ďay, Year) Injur 2 □ Accident investigation		njuryat Vork? □Yes 2□No	28d. Describe how injury occurred			
	tal or Affers as after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, offic			(Street and Number or Rural Route Number, own, State)		
	ne nospi in 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, di and manner stated. 15 Certifying Physician: To the best of my knowledge, di and manner stated.	ath occurred at the investigation, in n	e time, date and place ny opinion, death occu	e, and due to the ca irred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)	
	o the within 2 To the comple	Ž	29b. Signature and title of certifier	1	ense number		d. Date signed (Month	, Day, Year)	
	, /	-	20 Nama and address of parameter and the		0574	00 0	5/21/2010		
	Q V		30. Name and address of person who completed cause of death (Item 23a) (Type Lynn A Thomas, MD 1221 Mercantile	n Largo	MD 20774				
	Stat Registra	e ir	31. Date filed (Month, Day Year) 2 2010 32. Braistrar's Signature	parket					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician FIMOVE 0455 M 22 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ORT WASHINGTON Medical CT > (__ FORT WASHINGTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Months Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, Ite Medical Examinations inset to inclinical at 10b_County 10a State 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number SA 12. Was Decedent Ever in U.S. Armed Forces?

1 **Des** 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: UNK 1 ☐ Yes 2 No þ Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) FRANK Elementary/Secondary (0-12) College (1-4or 5+) UPERVISOR 2 774 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1AMES ٥ BENDETT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important; If item 27 is any injury or other trau once. ROUNDUP LUSBY MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 Burial 2 Cremation 3 Removal from State TARMONY Memora 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 420 HSt. 18 TIME WasH DC. 20002 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hear **Physician** disease or condition resulting in death) /Medical Examiner diomyo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence to The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Month Year Day 5 Other (specify) ☐Yes 2☐No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the funderlying cause given in Part I.

Part II. Other significant conditions contributing to death but not resulting in the funderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed ensio 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 1 ☐Yes 2 ☐ No al or Attending Physician: T s after death. al Director: After this certifica ed in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a

To the Funeral D To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 4674 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sachdeva Deepak M.D. 11 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 31 PM Kimberly Leanne Hyatt-Wallace 10 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Square Hospita er 1 Year | If Under 24 Hrs. timore Birthplace (State or Foreign Country) 7. Age In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 63 012-34-9507 Director 1946 Massachusetts June 15, Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits 10a. State 28a-f show if than "natural", or items 23a or 28a-f sho Director 1 □Yes 2 No Saint Clair Illinois Fairview Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Circle Drive 62208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 X No Specify. Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) Psychologist 5± Counseling land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental is marked John Zila Maude Elizabeth Hibbert ည Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any injury or other trau once. Chloe M. Wallace, spouse 108 Circle Drive Fairview Heights, IL 62208 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 06/01/10 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb Sed 299 Frederick Road BAltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Herniati -erebral /Medical Due to (or as a consequence of): Examiner Cerebrovascular Massive Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Atherosclerosis Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ormonal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? obacc 24a, Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 2√2No After this certification, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 □Yes 2 □No I Director: A investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dav. Year) 29b. Signature of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore, DriCarrie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year MES 10720 AM Medical 2-410 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HAR3OR OSAI altimace 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Social Security Number 213-76-6509 8. Date of Birth Month Day Year 67 42 Months Days Min. Director MD Usual Residence of Decedent 28a-f show 10a. State 10b. County ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director MD N/A Brooklyn YYes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 48 W. Talbott Street Funeral 21225 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐No Specify: Specify. white Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Roofer Construction other traumatic event, Be permit. Page 1 and 2 should be filed
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other them. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John F. Ireland Betty J. Lee 19a. Informant's Name/Relationship (Type, Print)

Love M. Ireland / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 W. Talbott Street, Brooklyn MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Cedar Hill Cemetery 5/28/2010 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Lunard Sizvice Licensee Victor Doda harTes L. Stevens Funeral Home, Inc. 1501 E. Fort Ave., Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End disease or condition Kys-Ny Medical resulting in death) **Examiner** Longesti Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (o. as a yonsequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) -burialattending physician Physician/Medical Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Dav 2 🗌 No as been signed by the 2 should be detached 9 Unknown 9 \ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has page performed? Yes 2 No 1 Yes 2 No completed filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide Investigation 24 hours after deatl Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 2 within 2 To the 1

15 V

State Registrar WICHER

31. Date filed (Month

DHMH 17 Rev 7/2009

3001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2010 **Physician** Mary Lee James 05 130 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battimore FRANKIN SQUARE
5. Social Security Number 6. So HOSPITA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days Hours Min 1 M 2 F Director South Carolina Apr.1,1924 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. It is mours after death with the Maryla Important: If Item 27 is marked other train "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Experient ment by notified at once. Rosedale Baltimore Maryland Director 1 □Yes 2 NO 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21237 5131 Castle Stone Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes M No Specify: Specify: Black þ 3

Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pimlico Hotel Cook 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mose Riley Daisey ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Conway Street Apt.708 Baltimore, MD 21201 Johnnie Lee James/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/2/10 Woodlawn, Maryland King Memorial Park 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Linesee 5240 Reisterstown Rd Baltimore, MD 21215 23a. Part 1. Phter the diseas shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Preumonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Yea Day 5 ☐ Other (specify) P.0. 1 □Yes 2 □ No. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s autopsy performe 1 ∐Yes 1 ☐ Yes 2 🗆 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 M Inpatient 2 ER/Outpatient 3 DOA After this 27. May er of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36663 27 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar DR. Stuart R.

31. Date filed (Month, Day, Year)

9000 Franklin Square Drive Ballimore, MD 21237

3. Time of Death

9:08 PM

Henrietta

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (if not institution, give street and number)

Lorraine

Physician/

Medical

Examiner

3500 Holmes Avenue N/ABaltimore 8. Date of Birth 9. Birthplace (State or Foreign 047041 Maryland 10d. Inside City Limits 1 ¥ Yes 2 □ No 10g. Citizen of What Country? U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Specify: Black 16b. Kind of Business Industry Clothing Factory 18. Mother's Name (First, Middle, Maiden Surname) Townsend Twonsend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3500 Holmes Ave., Baltimore, MD 21217 20c. Location - City or Town, State 06/07/2010Owings Mills, MD Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dving, such as cardiac or respiratory arrest Interval Between Onset and Death 23d Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes To the Hospital or Attending Physician: " within 24 hours after death. To the Funeral Director: After this certifics completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D35102 Moull 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHArles Street Baltimore Maryland 5901 north m.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Amend #5 & 18 per FH g904 6/2/10 TT State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Johnson

4b. City. Town, or Location of Death

2. Date of Death

30

Month

May

2<u>010</u>

4c. County of Death

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Lorraine Witherspoon Johnson 3:25 May 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 Months Days Hours 219-52-7143 Director Yrs. 58 06/02/1951 Maryland Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Funeral Director 1 √ Yes 2 □ No MD N/A Baltimore ò 10e, Street and Number 10g. Citizen of What Country? 23a 4221 Old Frederick Road 21229 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 X Divorced Black 15. Decedent's Education iit. Page 1 and 2 should be filed within 7.2 invariant of Health and Mental Hygiene. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Chemical Operator W.R. Grace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bennie Witherspoon Martha Harrell 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4221 Old Frederick Rd, Baltimore, MD DeJournette Moody Hines 21229 Department of Health Important: If item 27 any injury or other to once. 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 NBurial 2 Cremation 3 Removal from State Baltimore, MD King Mem. Park 06/04/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Joseph H. Brown Jr. Funeral Home, 2140 N. Fulton Ave., Baltimore,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ mydodysplastic disease or condition resulting in death) Medical Due to (or as a consequence f) Examiner Sequentially list conditions, Examine if any leading to it modificates. Enter Underlying Cause (Disease or iinjury Due to for as a ponswouence of physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical as. IF FEMALE: use 8 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ģ 5 Other (specify) Month Year Day this certificate has been signed by the raid director, page 2 should be detached it ☐ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Whether (Specify) V 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred e Hospital or Attending P 124 hours after death. e Funeral Director: After t 1 Natural 2 Accident 3 Suicide 5 Pending iniury work? 1 ☐ Yes 2 ☐ No M Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifier License number

State Registrar

Box 68760

P.O.

Records,

Division of Vital

6701

N. Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Figistrar's Signature

wa

16990

		4	For State	State of Mar		tificate of D			Reg. No.			
			Registrar 1. Decedent's Name (First, Middle, Last)			- D	out.	2. Date of Dea	ith		3. Time of Dea	ath
	Physicia		John Alvie 3	ohnson,	Jr.			May 3	31 Day 20	1 Čear	16:43	М
	Medical Examiner 4a. Facility Name (if not institution, give street and number)					4b. City, Town, or	Location of Death			nty of Death		
			Carroll Hosp	oice Dove	House	Westmi			Car	roll		
	Funeral Director	- 1	5. Social Security Number 6. Sex 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1		n yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Aug • 2	h (Ye ^{ar)} 196	g. Birthr	place (State or Fo. htry) aryland	oreign
			Usual Residence of Decedent					11149	, , , ,			
	f short	to	10a. State 10b. County		0c. City, Town or Loc					1	10d. Inside City Li 1 ☐ Yes 2X	
	Mary 28a-i otifie	. <u>≻</u> L	Maryland Carrol	. 1	Finksbur							71 NO
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Ind Mental Hygiene. Indexted other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	alD	10e. Street and Number 2017 Deer Park F	2.4		10f. Zip Code 21048	}		10g. Citizen o		ntry?	
	ath wi	Funeral		12. Was Decedent Eve	r in U.S. 13. V	Vas Decedent of His Yes, specify Cubar		ecify Yes or No-		ace - Americ	can Indian,	
0	or ite	by F	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give) If			Rican, etc.)		lack, White,		
<u></u>	ırsaft ıral", IExal		3 🗌 Widowed 4 🔲 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🔯 No	Specify:		Speci	ify: Whi	te	
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121	thin 7 ane. than he Me	No.	Elementary/Seconday (0-12)	College (1-4 or 5+)		o <i>notuse retired)</i> ster Car	penter		Self	Emp	loyed	
0 0	ed wi Hygi other ent, t	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surna	me)		
lan	l be fil fental rked tic ev	욘	John Alvie John	nson, Sr.			Romaine	e Krout	<u> </u>			
ary	1 and 2 should be file f Health and Mental item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street a	and Number or Rur	al Route Numbe	r, City or Town	, State, Zip	Code)	1
Σ.	nd 2 sealth m 27		Natalie Johnson	- wife		Deer Pa						
Baltimore, Maryland 21215-0036	. 0		20a. Method of Disposition 1 → Burial 2 → Cremation 3 →		20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	June 4	, ^D 2010	20c. Locatio	-		
Ħ	it. Pag rtmen rtant, njury		4 Donation 5 Other (Specify		Evergree	. Name and Addres			Finks			P. A
Ba	permit. Page Department. Important: I any injury or		21. Signature of Arraral Service License	hom	u 3	296 Cha	rmil Dr	. Manc	heste	r, MC	21102	
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Ę	Physic this c	6	1 Yes 2 No	1 Inpatien	t 2 ER/Outpatier	nt 3 🗆 DOA	4 L Nursing F	lome 5 Resi			M DOVE H	OUSe
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isio	l or Attending Ph after death. Director: After thi I in by the funeral	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury	/ - At home, farm, str	eet, factory, office		28f. Location (Street and Nur	mber or Run	al Route Number,	
Division of Vital Records,	tal or			building, etc.	(Specily)			City or 10	WII, State)			
	Hospi 24 hou Funer rted fill	Medical	(Check 2 Medical Evami	ician: To the best of m ner: On the basis of exa	mination and/or inves	tigation, in my opini-	on, death occurred	at the time, date	and place, and	due to the c	ause(s) and manne	er stated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use at	ž	only one) 3 Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the be	est of my knowledge,	death occurred at the 29c. Licens		ace, and due to t	29d. Date sig			
	H S H O		▶ Westerta	Rue my it	n	000	764597		6/1	1/10		
	12		30 Name and address of person who c							+ + +		
	100	1	What Rice 555	Dyuth Ce	uter Stre	et West	-IIDSTEF !	HD 21157				_
	Sta Registr		31. Date filed (Month, Day, Year)	Lucia A	s Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 316 RM Paul Lester James n au Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MUTE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number Sex 1XXM 2 □ F 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Year) 19<u>31</u> Months Hours Min. 79 New Jersey Director 148-30-7272 Usual Residence of Decedent shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Reisterstown 1 🗌 Yes 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 917 Lindellen Ave. 21136 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married XX Married 1 ☐ Yes XXNo Specify: "natural" Specify Completed 3 Divorced 4 Divorced 1956 White Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Business Machines Engineer Be and be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lester James Verna Scott Maryl Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 Margaret James / Spouse 917 Lindellen Ave. Reisterstown, MD 21136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important, If it any injury or o place of Disposition (Name of Cempton), State Cemetery, crematory or other place)

11 Faiths
12. Name and Address of Facility Eckhardt Funeral Chapel P.A. 1 Burial XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Freneral Service License 1605 Reisterstown Rd. Owings Mills, MD21117 mun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician a Valal disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant a 9 Unknown Month Day Year Pregnant at time of death Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ⚠ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐VAo မ 1 Mnpatient 2 DER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending n 24 hours and he Funeral Director; Af maleted filled in by the fi 2 Accident 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and little of Lertifier 29c. License number 29d. Date signed (Month, Day, Year) 000 May 30 2010 and address of person who completed cause of death (Item 23a) (Type, Print)

NOODA Park, MD Sinai Hospital 7 32. Registrar's S State

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Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Jackson McKinley Medical 2010 10:15a^M 05 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2807 Boarman Ave Baltimore Funeral 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 02 07 26 1 x M 2 □ F Hours Min. 251-38-8846 **Director** 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items ?? - - - any injury or other traumatic event, the Modifier of the process. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore MD NA 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 2807 Boarman Ave U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Tes 2 1 ☐ Yes 2 No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates. 15, Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th grade R. Grace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Jackson Edna Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2807 Boarman Ave, Baltimore, Md 21215 Louise Jackson-Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Woodlawn Woodlawn, Md 4 Donation 5 Other (Specify) 6/1/2010 21. Si hature of Funeral Service Ligensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EVERE SLEEP APNEA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MIN Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury East to for east consequences of Exam that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Yes 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown TAC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No After this certificate 1 Yes 2 No To the Hospital or Attending Physiolan: 'within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\overline{\Omega}\) Residence 6 \(\sum \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date at diplace, and due to the cause(s) and manner as stated. (Check 29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year)
MAY 25th 2010 MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 ANNAPOLIS RD. BALTIMORE MD 21227 MALIK, RABINA MD

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Eric Lee Jackson 2010 16993 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day May 24, 2010 Medical Examiner Eric Lee Jackson 1616 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 800 N Luzerne Avenue Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director 217-66-5648 1 XM 2 F 50 Country) MD Yrs 1-3-1960 Usual Residence of Decedent any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show a 1XX Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore na Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 N. Luzerne Avenue 21205 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Black Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry na during most of working life. DO NOT use retired) na Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Robert Jackson Lillian Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa McCov-Fiance Ν. Balto, MD 21205

20c. Location - City or Town, State Luzerne Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Garrison Forest 6-2-2010 Owings Mills, MD 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee March East F/H 1101 E. North Avenue Balto, MD 21202 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Hypertensive cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial - transit Physician/Medical X UNPENDED AMENDED 23a, PII, 27, per ME g904 6/15/10 TT The law requires that the death certificate be P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Year past 12 months? Day Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ chronic alcohol abuse; cirrhosis of the liver 1 Yes 2 No 3 Probably 4 ✔ Unknown leted Division of Vital Records, 24a. Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 🗸 Other: Scene 2 ER/Outpatient 3 DOA 1 V Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural within 24 hours after death. To the Funeral Director: Director: in by the f Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 25, 2010 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) OCIVIE 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 6994 State of Maryland / Department of Health and Mental Hygiene? State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Willie Edward Jordan 405 PM Ma Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctor's Hospital Lanham P.G. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 01-02-1925 N Country) 85 Director 246-26-0257 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director District Height's MD P.G. 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20747 2711 Boones Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Specify: Black If Yes, Give 1 ☐ Yes 2 X No Specify: "natural" Completed 3 ₩ Widowed 4 □ Divorced Year or Dates it of Health and Mental Hygiene.

If item 27 is marked other than "natur or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 7 th College (1-4 or 5+) Safeway warehouse man be filed Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Zillie Exum James Jordan permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)207472711 Boones Lane, District Height's MD. Billy R. Jordan/nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Suitland, MD Lincoln Memorial 5/29/10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
B.K. Henry Funeral Home Wash.DC., 20002 21. Signature of Funeral Service Licenses 23a. Part NEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician ERGBNOVASCULAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examine PROSTA Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury ue to firms a comea umnou off Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ă 1 Yes 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an infer death.

Director: After this certificate has the in by the funeral director, page 2 s autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 ► Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 2 MDD58/82 05/211 address of person who completed cause of death (Item 23a) (Type, Print) Suite 101A, Greenbeit, mb. 20170 MD . 7500 Hanover Parkway D. Georg 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month James Oliver Jiles 2010 Medical 3:45 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1036 Cresthaven Dr Silver Spring Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 **₹** M 2 □ F Min 02/25/1935 579-46-5885 75 **Director** DC Usual Residence of Decedent show 10a. State filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1036 Cresthaven Dr 20903 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 5 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black "natural", Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Program Analyst DC Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Elzenor Jiles Miranda Tinsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winifred A Jiles/spouse 1036 Cresthaven Dr Silver Spring, MD 20903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cem 4 ☐ Donation 5 ☐ Other (Specify) 06/07/2010 Brentwood, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Marshalls Funeral Home marshall M 00 4217 9th St NW Washington, DC 20011 23a. Pad 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Priysician disease or condition resulting in death) Metaststic Lung Cancer Medical Examiner Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death Unknown 9 🗌 Unknown been signed by ishould be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Seizure Disorder Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Cerebral Atrophy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2XX No Post Radiation Encepha Apathy After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner: Hospital Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury after death.

Director: Af d in by the fur Acciden
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined building, etc. (Specify) 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ertifie 29c. License number 29d. Date signed (Month, Day, Year) DC 14799 06/01/2010

State Registrar Irving St NW Suite 216 Washington, DC 20010

rson who completed cause of death (Item 23a) (Type, Print)

106

Arthur N West, M.D.

31. Date filed (Month, Da

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Barbara Denise Smith Jackson Physician/ Month May Day 2010 Year 30, 12:30 pM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Prince George's Examiner 4b. City, Town, or Location of Death 2345 Iverson Street Temple Hills Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country) D.C. 1 M 2 X F 55 579-72-2817 0970471954 Director Usual Residence of Decedent 28a-f shov ould be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Temple Hills 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2345 Iverson Street 20748 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or . Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Receptionist traumatic event, Be 17. Father's Name (First, Middle, Last)

James Arthur Smith permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Lizzie Ruth Smallwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2345 Iverson Street, Temple Hills, MD 20748 Iris Elaine Smith / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Final Journey Crem. 6/2/2010 Woodbine, MD 22 Maryland Cremation Services peral Service License Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Bety Immediate Cause (Final Trysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, healing to immediate cause. Enter Underlying Cause (Disease or injury) that initiated so or injury Examiner Due to jor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 No death? 1 Yes 2 No eral Director: After this certific filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Accident Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours Medical 29a. Certifier 1 (XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor **To the Fune** completed fi Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Murse Plactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier signed (Month, Day, Year) (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	State of Maryl		ertificate of L			ene 2010 g. No.	16997	
П	Physicia	ın/	1. Decedent's Name (First, Middle, Las		T 1			2. Date of Death Month	Dav Year	3. Time of Death	
Medical Examiner			Alan Joseph 4a. Facility Name (if not institution, give street and number)			Johnson May 4b. City, Town, or Location of Death			26, 2010 8:30 A M		
< 1		ш	50 Philadelphia 5. Social Security Number 6. Se				oma Park	Lo Bar at Britis	Montg		
	Funeral Director		5. Social Security Number 216-50-8993 Usual Residence of Decedent	rs. last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Jan 2	ear) 1948 Was	thplace (State or Foreign untry) hington DC		
	land show	ţō	10a. State 10b. County		. City, Town or L					10d. Inside City Limits	
	r 28a-i notifie	Funeral Director	MD Montgon	nery		Takoma Pai	rk			1 X Yes 2 □ No	
	with th	erall	50 Philadelphia	Ave.		209	912	10	g. Citizen of What Co United S	-	
9	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 【XNo	1 U.S. 13	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	rican Indian, e, etc.	
Maryland 21215-0036	nours al latural" Ical Exa		3 Widowed 4 Divorced	If Yes, Give Year or Dates.	16a, Dec	1 ☐ Yes 2 ☒ No edent's Usual Occup		I.	Specify: W 6b. Kind of Business	hite	
1215	thin 72 I ine. than "r ie Med	Completed	(Specify only highest gra	de completed) College (1-4 or 5+)	(Give	kind of work done of DO NOT use retired)	during most of work	ing		·	
9 5	iled wit Hygie other rent, th	Be	17. Father's Name (First, Middle, Last)	1	Scu.	lpture / A		e (First, Middle, Ma		ulpture	
ylan	ild be f Menta narked atic ev	욘	John L.		nson		Helen		abeth	Conley	
Mar	12 shou alth and 27 is m r traum		19a. Informant's Name/Relationship (Ty Karen L. Johnson)			ing Address (Street o Philadelph			ity or Town, State, Zig Park, MD	Code) 20912	
Baltimore,	age 1 and ant of Hez ht: If item y or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	b. Place of Disp	osition (Name of ematory or other place to 1n Cemet	re)	Date 2	Oc. Location - City or Brentwood		
Baltir	permit. P Departmot Importar any injur once.		21. Signature of Funeral Service Lice	Ma1539		2. Name and Addres (app Funer)33 Gist A				0910	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	olications that caused the d						Approximate Interval Between	
P	nysician/ Medical		Immediate Cause (Final disease or condition and Death an								
-	Examiner		Alyponic obstructive laure disposer Z							Zueary	
7	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a cons		υή:					
	e executivian and arial-trar	al Exa	that initiated events resulting in death) Last	C. Due to (or as a cons	sequence of):				_		
09/	cate be physic sthe bi	ledical		d							
Box 68	death certificate be executed the attending physician and led for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	y		23d. Date of del Month	ivery Day Year	
О.	gnec gnec	ρ	Part II. Other significant conditions co	ntributing to death but not	resulting in the	underlying cause giv	ren in Part I.		cco use contribute to		
ords	been s	leted						1 Yes 24a. Was an		robably 4 Unknown	
Vital Records,	ine iaw ate has page 2	Completed						autopsy performe	prior to d	completion of cause of	
Ita	certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:		Othe	ace of Death (Checker:	only one)			
ot o	to the nospital or Attending raystoan. The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	ate: To	27. Manner of Death 1 Natural 5 □ Pending	1 Inpatient 2 28a. Date of injury (Month, Day, Year,	28b. Time o	ont 3 □ DOA of 28c. Injury work	4 ∐ Nursing Ho ∕at ?	me 5 Residence 28d. Describe how	ce 6 Other (Speci injury occurred	ify)	
Division of	r Attend ter death rector: /	Certificate:	 Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Description Descrip	28e. Place of Injury - Afbuilding, etc. (Spe		M 1 🗆 Yes 2 🗆 No			reet and Number or Rural Route Number,		
בֿ בֿ	hours at neral D	Medical C	29a. Certifier 1 Certifying Phys	ician: To the best of my kn	owledge, death	occured at the time,	date and place, an	d due to the cause	(s) and manner as sta	ted.	
1	ithin 24 the Fu	Mec	(Check 2 Medical Examinonly one) 3 Certifying Nurs 29b. Signature and title of certifier	ner: On the basis of examina e Practioner: To the best of	ation and/or inver f my knowledge,	death occurred at the	time, date and plac	e, and due to the ca	place, and due to the cluse(s) and manner as	stated.	
	- 3 - ō		> Multh 4	-itant			906	le	124.27,	2010	
	2		30. Name and address of person who co	ompleted cause of death (If	tem 23a) Type,	Print) ZSU	Takou	ua Park	a lud	20912	
Ę	Stat Registra		31. Date filed (Month, Day, Year) JUN 0 2	2010 Registrat's Sig	gnature A.	pare		, ,,,,	10000		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **Demetrius Jones** 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day May 27, 2010 Medical Examiner Demetrius Tony Jones Sr. 0051 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Maryland General Hospital Baltimore n/a 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funeral Months Days Hours Director 06/08/1957 1X M 216-68-4970 52 Country) MD Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No or items 23a or 28a-f show must be notified at once. MD Baltimore n/a permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Impogrant! (I filem 27 is marked other than "natural", or items 23a or 28a-f sho injury For other tranmatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21201 1032 Stoddard Court USA Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. 2 X No African-American Yes Yes 2 No specify: 3 Widowed 4 Divorced f Yes, Give Year ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction GED Laborer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Sumame) Edward Louis Jones
19a. Informant's Name/Relationship (Type, Print) Marie Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1032 Stoddard Ct Baltimore, MD 21201 Tracey Jones-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 6.2.2010 Baltimore, MD Baltimore Crematory Donation 5 Other Specify Z2 Name and Address of Facility
John L. Williams Funeral Directors, P.A.
4517 Park Hgts Ave Baltimore, MD 21215 gnature of Funeral Ser Part I. Enter the disease, or complications to used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and (Medical Death a Epidural abscess and osteomyelitis of the lumbar Immediate Cause (Final disease .xaminer or condition resulting in death) Due to (or as a consequence of): spine Sequentially list conditions, Dianto (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit The law requires that the death certificate be executed d Physician/Medical signed by the attending physician a be detached for use as the burial -X UNPENDED 23a, PII,27,per ME G904 6/17/10 TT as noted, Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the I ive birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive cardiovascular disease Completed After this certificate has been a funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No death? 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 🗸 Inpatient 2 Other Nursing Home 5 Residence 6 Other: ER/Outpatient 3 DOA 1 Yes No Director: After to in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Division 5 Pending 1 Yes 2 No 2 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be To the Hospital of within 24 hours at To the Funeral I determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 28, 2010 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 22 Physician/ Kaminkow anotte 1426 PM 2010 Medical Ma 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hopkins Bayview Medical Contr. timore N/A 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of b... (Month, Day, 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8. Date of Birth 1 □ M 2 😾 F Days Director 214-40-1527 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Edgemere 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral and 2 should be filed within 72 hours after death with t Health and Mental Hyglene. Iem 27 is marked other than "natural", or items 23a United States 4712 Greencove Circle 21219 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Underwriter Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Frances Marie Smith Harry Kaminkow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4712 Greencove Circle Edgemere, Maryland 21219 Nanci Lee Wheeler (Daughter) Department of Health Important: If item 2 any injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Hilltop Service Corp. 5/25/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Lice ²² Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise <u>Ave</u>. Dundalk, Maryland 23a. P.m. 1. Enter the disease, or of inflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he of faithre. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ llespit-tory disease or condition deys Medical resulting in death) Due to (or as a consquence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hematoma death certificate be executed the burial-trans that initiated events resulting in death) Last physician Be Completed by Physician/Medical Box 68760 attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day been signed by the should be detached P.O. I of or Attending Physician: The law requires that the after death.

Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 Tes Division of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 0 2 🗌 No Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Fe11 nknown Unknown M Investigation 1 Yes Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1-lome 4712 Green cove Cr, Spirs Point MD, 21219 Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title RES-600 May 22, 2010 erson who completed cause of death (Item 23a) (Type, Print) stin Eastern Avenue Baltimore, MD 21224 plan, M.D. 4940 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ EVa Kasten Month AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Seasons Hospice & Palliative Care Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 X F Months Days Hours Min. 0970571919 Pennsylvania **Director** 220-22-8595 90 Yrs Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. That: If item 27 is marked other than "natural", or items 23a or 28a-f sho itny or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Baltimore Middle River 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1320 Windlass Drive 21220 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clement Costenbader Mazie Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Dawson (Personal Rep.) 502 Crisfield Road, Baltimore, Maryland 21220 Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 06/010/2010 Baltimore, Maryland . Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Cardiovascular Disease Atheroscientic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? been signed by the atte should be detached for Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? certificate 2 - No 1 Yes 2 No Yes 25. Was case referred to medical completed filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) in-parent hospice 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as stated.

2 I Medical Examiner: On the basis of examination and/or investigation, in my onlying, date and place, and due to the cause(s) and I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d, Date signed (Month, Dav. Year) ► MSRajapaRse M.D D0057465 3/28/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) By 15 more, MD. 21209. 2835 Smilh Av- 5-235, N.S. Rajapakse, M.O 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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